Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Deborah Cole-Hammond Selotember 8 2010 1:00PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 701 Glenwood St. Apt 606 Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Months Min Hours May 25 Year 968 217-74-5776 42 Director Marvland Usual Residence of Decedent items 23a or 28a-f shover must be notified at 10a, State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 701 Glenwood St. Apt 606 21401 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examinar mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 δ 1 Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 11th 0 Custodian State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marvin Cole Regina Queen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Hill(Aunt) 701 Glenwood St. Apt 606 Annapolis, Md.21401 20a. Method of Disposition
1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State metro Crematory or other place, 9-15-10 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Mamama Record AciliSons Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 Beese MOSY8 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death hysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 No q | Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed icate has been sig 7, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 🕱 No To the Hospital or Attending Physiciam: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 \square Pending (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

BALTIMORE MD 21202

			For State	State of M	1arylan	d / Depa	artment of tificate of	Health	and Me			010	30502
			Registrar 1. Decedent's Name (First, Mide	dle, Last)		Oci	incate or	Death		2. Date of Dea	Reg. No. ath		3. Time of Death
н	Physicia Medi		Ange	elo DiLonardo)					sept.	22°,	2010	07/5AM
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I	´		15 A 5. Social Security Number	Ashbury Ave.	// /-	at histodou)	LaVale	Tif I Indo	er 24 Hrs.	0 D-1(D)-1		llega	
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	yland -f shc ed at	ctor	10a. State 10b. Coun	•		y, Town or Lo	cation						10d. Inside City Limits
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	and 2 Health em 27 ther to		Desiree Un 20a. Method of Disposition	iver DiLonar			hbury Av	re., I			21502	O't	Town Others
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altii	permit. P Departm Importar any injur		21. Signature of Funeral Service		7	4.00	Name and Addre						
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-	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a	Lin	ev	circho	212					Onset and Death
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Box 687	eath certifica attending p	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome			Ectopic pregnan	CV			23d.	Date of de	livery
Bo	Hospital or Attending Physician: The law requires that the death certificate be executed 424 hours after death. Funeral Director. After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Physician/M	1 Yes 2 No 9 Unknown	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify) _					Month	Day Year
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۵	To the Hospital or Attend within 24 hours after death To the Funeral Director: completed filled in by the		29a. Certifier 1 Certifyir	ng Physician: To the best of	f my knowle	edge death o	ccured at the time	date and	I place and	due to the cau	se/s) and ma	nner as sta	ited
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			30. Name and address of persor I daluna G 31. Date filed (Month, Day, Year)	who completed cause of a	leath (Item:	23a) (Type, P	int) V Cas e	nbe	Am	d m	0 2	150.	2
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Year Dovel Month **Physician** 0220aM Anna September 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital Baltimore Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under Months Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex **Funeral** Days 1 ☐ M 2 🖫 F 216-12-5745 Yrs. MARYLAND **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10h County if than "natural", or items 23a or 28a-f show the Medical Examinating that be notified at 1 ☐ Yes 2 No Completed by Funeral Director EN BURNIE 10e. Street and Number 10g. Citizen of What Country? 313 HOSPITAL DR 2106 . 4 ـ ک. ر 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █️No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: 3 ₩idowed 4 Divorced ShiTE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important; If item 27 is any Injury or other trau once. MILDRED CAMPSELL, SISTER STI ARLUNE DR. ARNOLD, MD. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State -22-10 4 ☐ Donation 5 ☐ Other (Specify) AKEVIEW MEMORIALD SYKESVILLE, MD. 2601 HOUNTAIN RD. HKADENA notice atoms that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the diserse, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Respira cardio **Physician** /Medical Due to (or as a consequence of): Examiner Stenosis Arstic SEVER Se uentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hypotensi an requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 \(\sumeq\) Yes 2 \(\sumeq\) No this certificate 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral in the fun 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

park

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PADMINI

ANASINGHE

32. Regis ar's Signature

D64894

600 North Wolfe St, Baltimore, MD, 21267

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	°		/rest	hr					MD 0	21.71			C	. 1	2 1	010	
	>		30. Name and address	of person who	completed cause of	death (Iten	1 23a) (Tvne	Print)	צעוייו	3474			ьер	L. 1	3, 2	010	
					M.D., 31	301 N	ew Mex	ico A	ve-	N.W	Was	hingto	n. D	.C.	2001	6	
	Sta	te	31. Date filed (Month, 1	Day, Year)	32 Regist	rar's Signa	ture fa	11									
	Registr	ar	SEP	14 20	10 Delser	as to	. Apa	174									

DHMH 17 Rev 1/2001

			For State	State of Ma		ertificate of			711	10	30505
		pt.	Registrar 1. Decedent's Name (First, Middle, L	.ast)		initiate of	Death	2. Date of Dea	ath		3. Time of Death
	Physici		Ruth Eileen Tho		rich			Month August	31 20	10 Year	3:30 P M
	/Medic Examin		4a. Facility Name (If not institution, g			4b. City, Town, o	r Location of Death			y of Death	
-0			Collingswood N			Rockvil1				gomer	•
	Funeral			Sex 7. Age 1 ☐ M 2 🔀 F	(In yrs. last birthda,	/) If Under 1 Year Months Days	Hours Min.	8. Date of Birt	v. Year)	9. Birth	olace (State or Foreign ntry) Ohio
Ŗ,	Director		271-30-3681 Usual Residence of Decedent		75 Yrs.			May 7,	1935		OHIO
	yland now at		10a. State 10b. County		10c. City, Town or	_ocation					10d. Inside City Limits
	e Mar ka-f st	ctor	MD Montgo	nery	Rockvill	e					1 ☐ Yes 2X No
	or 28 oe no	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of		
	s 23a	eral	17012 George Was	hington Driv		208 Was Decedent of F			United		S can Indian,
_	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status1 ☐ Never Married2 ☐ Married	Armed Forces? 1 ☐ Yes 2★ N		If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Bla	ack, White,	
215-0036	ours a ral", o Exam	b	3 Nidowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐xNo	Specify:		Speci	Whi	te
ر م	72 hc 'natu dical	Completed	15. Decedent's (Specify only highest of	Education grade completed)	16a. Dec	edent's Usual Occup re kind of work done DO NOT use retire	nation during most of work	king	16b. Kind of E	Business/In	ndustry
7	filed within 72 h I Hygiene. other than "nati ent, the Medica	ld m	Elementary/Secondary (0-12)	College (1-4or 5-	-}		a)		Lega1		
7	filed Hygie ther int, th	ပိ	17. Father's Name (First, Middle, La	st)	1 56	cretary	18. Mother's Nam	ne (First, Middle,			
/land	ould be Mental larked o	To Be	Richard Thomps	on			Lillian	stillw	e11		
Mary	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship			iling Address (Street					
	and 2 ealth a n 27 Is ner trai		Melissa Griffit	h/Daughter		12 George					
0	Pages 1 and 2 should ment of Health and Mer ant; If item 27 Is marke ury or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3	☐Removal from State	20b. Place of Dis	position (Name of rematory or other pla	ce)	Date	20c. Location	- City or T	own, State
Baitimore,	Pa men ant: ury		4 □ Donation 5 □ Other (Spe			oln Crema 22. Name and Addre			Brent	wood.	_ MD
g n	permit. Departi Importa any infi once.		21. Signature of Funeral Service Lic	ensee M	01463	1040 Rock				MD 20	0852
	W -50		23a. Part1. En r he dis ase, or co shock, or he rt fail re. List on	omplications that caused	the death. No not e						Approximate Interval Between
,	Physician		Immediate Ca (Final disease or condition resulting in death)	3		ment	OL.				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	1 1	D'I 7	1-			
		<u>_</u>	Sequentially list conditions,	b. Dun to due on a	C)	/ww/	/J MAC	rd Han			
	Ited Insit	Examiner	Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	But 15 (5) 400 5	econocido sign	Sierr	A 4 a				
<u></u>	be executed ician and burial-transit	Exal	resulting in death) Last	C Due to (or as a	consequence of):	<u>Sieu</u>					
8/6U	ficate be executed physician and the burial-transit	dical		d	(July	W				
٥	ertifica ling ph e as t	Med	IF FEMALE:					OH-7			
X Q Q	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1 ☐ Live birth 4 ☐ Pregnant at	2 ☐ Fetal death	B ⊟Ectopic pregnanc	y			ate of deliv Nonth	very Day Year
j.	the de	ysic	1 Yes 2 No 9 Unknown	9☐Unknown	unie or deam	J⊟ Other (specify) _					
7	s that ned by		Part II. Other significant condition	s contributing to death bu	t not resulting in the	underlying cause giv	ven in Part I.	23e. Did t	tobacco use co	ntribute to	the cause of death?
Hecords,	quires en sign uld be	ed by						1 🗆	Yes 2 □ No	3 ☐ Pro	bably 4 Unknown
ပ္ပ		Completed						24a. Was		. Were aut	opsy findings available ompletion of cause of
	sician: The law scriffcate has b irector, page 2 sl	mo/						perfo	ormed? 2 □ No	death? 1 □ Yes	2 X No
VITal	Physician: r this certific ral director,	Be (25. Was case referred to medical examiner?	Linevitel:		Loui	26. Place of Dea				
_	≥ .≅ ₽	은	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatier	<u>`</u>	ent 3[] DOA		lome 5 Resi	idence 6 🗆O		ify)
0	ding h. After funer	tion	1 Natural 5 Pending 2 Accident investigat	(Month, Day	Year) Injur	/ Wo	rk?]Yes 2 ⊟No	Zou. Describe	now injury occi	ullou	
UIVISION	Atten r deat ector; by the	fica	3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of inju		I street, factory, office		28f. Location (Street and Nun	nber or Ru	ral Route Number,
5	tal or s afte al Dir ed in l	Certification:	4Hornicide	building, etc	. (Specify)			City of 10	wii, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		(Check only 2 Medical Ex	Physician: To the best of caminer: On the basis of	examination and/or						
	thin 2 the omplet	Medical	one) 29b. Signature and title of celtifler	and manner sta	ted.	29c. Licens	se number		29d. Date sign	ned (Month	, Day, Year)
			AH	D M	\cap	0	25.500	44	G	11	01/
r	3		30. Name and address of palson wi	no completed cause of de	eath (item 23a) (Typ	e, Print)	-	•			-
			Ahmed Heshmat	7133 Millrur	Dr. Derv	vood, MD 2	20855				
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	V.0					
	Regist	ar	SEP 1 5 201	U priseras	pa. pagar	The state of the s					

			For State	State of Ma	aryland / Depa	artment of He rtificate of De	ealth and N eath			10	30506
			Registrar 1. Decedent's Name (First, Middle	, Last)	<u> </u>	tincate of De	calli	Re 2. Date of Death	g. No.	_	3. Time of Death
	Physicia Medic		Charles Gordon	Davidson				Month Septemb	Day	Year 2010	1.01
and the same of	Examir		4a. Facility Name (if not institution	-		4b. City, Town, or L			4c. County		-
	•		12308 Selfride				er Sprin		Mor	ntgom	ery
E	Funeral Director		5. Social Security Number 214-52-2605	6. Sex 1 ★ M 2 □ F	(In yrs. last birthday) 57 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y May 1,	(ear) 1953	9. Birthp Count	olace (State or Foreign try) MD
	and show	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				11	0d. Inside City Limits
	Maryla 8a-f tified	Director	MD	Montgomery	Silv	er Spring					1 ☐ Yes 2 🏋 No
	the la or 2	٥	10e. Street and Number	<u> </u>		10f. Zip Code		10	g. Citizen of W	/hat Coun	try?
	h with	Funeral	12308 Selfric	ge Road		20906			USA		
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 【本Mar 3 ☐ Widowed 4 ☐ Divorced	If Van City	No I	Vas Decedent of Hisp f Yes, specify Cuban, □ Yes 2 X No	Mexican, Puerto	cify Yes or No- Rican, etc.)	Black	e - America k, White, e Whit	etc.
5-(2 hou "natu edica	blet		nt's Education est grade completed)	16a. Deced	lent's Usual Occupati kind of work done dur	ion rina most of workii	ng 1	6b. Kind of Bu	siness Ind	lustry
121	thin 7 ene. than be M	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	+) life. Do	O NOT use retired)					
d 2	ed wi Hygie other ent, ti	Be (17. Father's Name (First, Middle, L	ast)	ETe	ctrician	18 Mother's Name	(First, Middle, Ma	Contra		g
lan	be fil lental rked ric ev	2	Robert Davids	*		['		rginia Ch			
Maryland 21215-0036	2 should th and N 27 is ma traumat		19a. Informant's Name/Relations Mary Ann Davi		19b. Mailir 1230	ng Address (Street and 8 Selfride	d Number or Rura	Route Number, C	ity or Town, St	ate, Zip C	ode) 20906
ē,	l and 2 s f Health item 27 other tra		20a. Method of Disposition	<u> </u>	20b. Place of Dispo		I		Oc. Location -		
altimore,	:. Page tment of tant: If jury or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		cemetery, cren	natory or other place) itan Crema	i	8 14	Alexan	-	
Ba	permil Depar Impor any in		21. Signature of Funeral Service L	icensee May	2 2 500	Name and Address rancis J. Universit	Collins ty Blvd.	Funeral W., Silv	Home I	nc.	MD 20901
			23a. Part 1. Futer the disease, or shock, or heart failure. List of	complications that caused	the death. Do not ente						Approximate
d	hysician/	i a	Immediate Cause (Final disease or condition	Acute Myoca		rction				- 1	Interval Between Onset and Death 5 mins.
	Medical Examiner		resulting in death)		consequence of):						
	ZAGIIIIIOI	ŗ.	Sequentially list conditions,	Coronary A:		ase					unknown
	sit 0 ed	Examiner	if any leading to know det cause. Enter Underlying Cause (Disease or linjury	Clied to for each	noinequeres of:					- 1	
	al-trar		that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					-	
0	icate be executed physician and strength the burial-transit	edical		d							
8760	tificate ng phy as th	Med	IF FEMALE:								
. Box 68	the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	e of deliver th [ry Day Year
9. O	requires that the de been signed by the should be detached	by P	Part II. Other significant condition	ns contributing to death bu	t not resulting in the ur	nderlying cause given	in Part I.	23e. Did tobac	cco use contrib	oute to the	e cause of death?
ds,	quires en sig ruld be							1 🗆 Yes	2 🔀 No 🤇	3 🗌 Proba	ably 4 🗆 Unknown
ecor	law rec has bee ye 2 sho	Completed						24a. Was an autopsy	pr	ere autops for to comeath?	sy findings available npletion of cause of
ř =	sician: The la certificate ha irector, page 2					00 DI		performe	No 1	Yes 2	2 □ No
Vita I	ysician: is certific director,	To Be	examiner? 1 Yes 2 No	Hospital:	nt 2 ER/Outpatien	Other:	of Death (Check		• 🗆 • •	(5)	
o t	g Phy er this		27. Manner of Death	28a. Date of injury	28b. Time of	28c. Injury at		ne 5XXResidend 8d. Describe how			
ou	endin sath. or: Aft	licat	1 X Natural 5 ☐ Pending 2 ☐ Accident Investig	ation	Year) injury	M 1 ☐ Ye	s 2 🗆 No				
Division of Vital Records, P.O.	al or Attus s after de l Directo d in by ti	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi		y - At home, farm, stre (Specify)	et, factory, office	2	8f. Location (Stree City or Town, S		or Rural F	Route Number,
- :	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical	(Check 2 L Medical E	Physician: To the best of maximer: On the basis of examiner:	amination and/or investi	gation, in my opinion, i	death occurred at t	he time, date and p	place, and due t	to the caus	se(s) and manner stated.
:	To the within To the compl		only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practioner: To the b	est of my knowledge, d	29c. License nu			use(s) and man		
	4		> Munn "	CWelinh		D 23	392 M	0	9/13/10	,	
	`		30. Name and address of person w	rho completed cause of dea E. Wilson, J		int) 00 Connect	icut Ave	nue, Ken		n, Mđ	20895
	State Registra	_	31. Date filed (Month, Day, Year) SEP 15 20	32. Registrar				,	J - 3		
			ULI AU ZU	1 for Estat But	100						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary		ertificate of D			eg. No. 2010	30507
	Physici		1. Decedent's Name (First, Middle, La Jagdish	st) Chander Dheman				2. Date of Death	n Bay 2010 Year	3. Time of Death 12:40 PM
	/Medic		4a. Facility Name (If not institution, giv			4b. City, Town, or I	ocation of Death		4c. County of Death	
			18414 Beechnut Way	7.1		Boyds	If I Indox 04 Hrs. T		Montgomery	
	uneral Director		5. Social Security Number 6. S 219-35-0945 1 Usual Residence of Decedent	2 F 7. Age (In	yrs. last birthda Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day, November	^{Year)} 25, 1933 Ir	place (State or Foreign Intry) Idia
yland	at at		10a. State 10b. County	100	. City, Town or	Location				10d. Inside City Limits
e Mar	Ba-f sh	ctor	Maryland Montgome	ry	Boyds					1 ☐ Yes 2 🔀 No
ath with th	23a or 2	Funeral Director	18414 Beechnut Way			10f. Zip Code 20841		10	0g. Citizen of What Cou USA	ntry?
d 21215-0036 Iffed within 72 hours after death with the Maryland	in results and welfard hygelies in them \$23a or 28a-f show then 21 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exemples must be notified at	þ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever i Armed Forces? 1Yes 2No If Yes, Give Year or Dates:	in U.S. 1	3. Was Decedent of His If Yes, specify Cuban 1 □ Yes 2 No	panic Origin? (Spe , Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Asi	etc.
21215-0036 od within 72 hours aff	than "natur e Medical I	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Gi	cedent's Usual Occupative kind of work done due. DO NOT use retired)	tion Iring most of workin	na l	16b. Kind of Business/Ir United States Government	,
filed v	other t		17. Father's Name (First, Middle, Last)	4	Cnie	f Accountant	18. Mother's Name	(First, Middle, M		
arylan should be	rked c	To Be	Sadhu Singh Dhem				Santo Dev			
, Mary and 2 shor	27 is ma er trauma		19a. Informant's Name/Relationship (Lakhjit Kumar Dheman	**	177	ailing Address (Street ar 4 Beechnut Way			. City or Town, State, Zi 0841	p Code)
Baltimore, Maryland	Department of near Important: If item 2 any Injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Hemovai from State		sposition (Name of rematory or other place,			Clen Burnie,	
Balti permit.	Importa any Inju		21. Signature of Funera Service Licer			22 Name and Address Fleck Funera	of Facility al Home, IN	C	, Maryland 207	
) /N	of physician and ledical aminer as the burial-transit	al Examiner	23a. Part1. Enter the disease, or composed with the control of the	b. Due to (or as a con Due to (or as a con Due to (or as a con	elod sequence of).	enter the most of dying	•	r respiratory arre		Approximate Interval Between Onset and Death
C. BC		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliv	very Day Year
ecords, P.	n signed l	þ	Part II. Other significant conditions o	ontributing to death but not	resulting in the	underlying cause giver	in Part I.	23e. Did tob	acco use contribute to to	the cause of death?
r _e	After this certificate has been signed by the attendifuneral director, page 2 should be detached for use	Completed	05 W					1	prior to co death? 1 Yes	opsy findings available ompletion of cause of
OT VII Physicia	this cert if directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpat	Othor	26. Place of Death 4 □ Nursing Hon		nce 6 ☐Other (Speci	
SION (or: After he funera	ation:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		r) 28b. Time Injury	y Work?	at 2 es 2 □ No	28d. Describe how	w injury occurred	
UIVI:	To the Funeral Director: After this certifics completely filled in by the funeral director, p	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, pecify)	street, factory, office	2	8f. Location (Str City or Town,	reet and Number or Rur , State)	al Route Number,
he Hosp	he Fune pletely fil	Medical	29a, Certifier (Check only one) Certifying Ph 2 Medical Exan	ysician: To the best of my niner: On the basis of exar and manner stated.	knowledge, de nination and/or	eath occurred at the time investigation, in my opi	e, date and place, a nion, death occurre	and due to the ca ed at the time, da	ause(s) and manner as ate and place, and due t	stated. to the cause(s)
To t	To t	Σ	29b. Signature and title of certifier	4.	SH)	29c. License	05634	29	ed. Date signed (Month	Day, Year)
CX	3		30. Name and address of person why on Piyush K. Patel, MD,	completed cause of death (Item 23a) (Typ		land 20906		1/ /	
·	Sta Registra	e	31. Date filed (Month SEP 1 3 2		gnature					

DHMH 17 Rev 1/2001

			State of Maryland De State of Maryland De Per verb., 8907,0	9/28/2016di ertificate of D	ealth and Mer No Death	ntal Hygie Reg.	ne № 11 (30508
			negistrar Decedent's Name (First, Middle, Last)		2.1	Date of Death	6010	3. Time of Death
	Physici		Jean Elizabeth Day			Month ept. 8	. 2010	3:40 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or I			4c. County of [
			1402 N. Tucker Rd	Street	:		Harfor	·d
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Ye	9.	Birthplace (State or Foreign Country)
	Director		212-28-1516 1□M ※AF 82 Yrs.	monare Baye		/8/192		Maryland
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits
	laryla sho	5						1 □Yes 2 ☑ No
	the N	Director	MD Hariord Bel A	10f. Zip Code		10a.	Citizen of Wha	t Country?
	aa or		128 W. Ring Factory Road	210	14		USA	
	filed within 72 hours after death with the Maryland Hygiene. Uther than "natural", or Items 23a or 28a-f show ent, the medical Examination routhed at	Funeral	11 Marital Status 12, Was Decedent Ever in U.S. 1	3. Was Decedent of His	spanic Origin? (Specify	Yes or No-		American Indian,
ဖွ	after or ite		Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2 ☐ VNo	n, Mexican, Puerto Rica Specify:	an, etc.)		Vhite, etc.
21215-0036	ours iral",	d by	XX Widowed 4 □ Divorced Year or Dates:	Thes 2	<i>Specily.</i>		Specify: Wh	ite
5-	72 h "natu	lete	(Specify only highest grade completed) (Gi	cedent's Usual Occupa ve kind of work done du	uring most of working	16b	o. Kind of Busin	ess/Industry
12	vithin ene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	o. DO NOT use retired) usewife		0	wn Hom	ne.
	filed v Hygid ther		17. Father's Name (First, Middle, Last)		18. Mother's Name (Fig.			
Maryland	d be ental ked o	To Be	Byron Caulford		Ruby Ha		,	
Z.	shoul nd M mar	F		uiling Address (Street a	nd Number or Rural Ro		ity or Town, Sta	ite, Zip Code)
			Connie Wallace/Daughter 13	20 Grafto	on Shop R	oad, B	el Air	, MD 21014
J.e.	of He of He item		cometen/ c	position (Name of rematory or other place	Date			y or Town, State
Ĕ	Pages 1 nent of h ant: if ite ury or ot		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ☐ Evans	Eagle Cre	em 9/10/	2010	Leola,	PA
Baltimore,	permit. Pages 1 al Department of Hec Important: if item any injury or othe		21. Signature of Fon in Service Lices e	22. Name and Address	,			17314
_	e a E e a		C. Robert polinaan	arkins F.	H.Inc.,60	00 Maiı	n St.D	elta,PA
			23a. Part 1. Enter the disease or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying	g, such as cardiac or re	spiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	na				Onset and Death
	/ /Medical Examiner		resulting in death) Due to (or as a consequence of):					
	LAAIIIIIei	_	Sequentially list conditions, b.					
3	ted nsit	nine	Sequentially list conditions, if any, leading to immediate charter Enties Enties that triping Cause (Disease or injury that initiated events					19
	icate be executed physician and the burial-transit	Examine	that initiated events c. The sulting in death content of the					
58760,	e be o	dical E						
289			u.	W				
2×	The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date o	f delivery
CA W	deatl	icia	in the past 12 Jonths?	3 □ Ectopic pregnancy 5 □ Other <i>(specify)</i>			Month	Day Year
4 O	it the by th	hys	9 Unknown					
0,8	as tha gned	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giver	n in Part I.	23e. Did tobac	co use contribu	ite to the cause of death?
- Pro	equin	ted				1 🗌 Yes	No 3[☐ Probably 4 ☐ Unknown
200	e law r has be	Completed				24a. Was an autopsy	24b. Wer	re autopsy findings available r to completion of cause of
THE H	The lav	Son				performed 1 ☐ Yes 2	dea dea	th? Yes 2 No
/ita	Physician: Th r this certificate ral director, pag	Be (25. Was case referred to medical examiner?		26. Place of Death (C	heck only orle)		Conta
of	Physical this cal direct	၉	Hospital: 1 Inpatient 2 ER/Outpat		4 Li Nursing Home			Son's (Specify) Residence
u	ffe Ing	io	27. Mappier of D ath 1 Alatural 5 Pending (Month, Day, Year) 1 Injury (Month, Day, Year)	/ Work?	at ? ′es 2 ∐No	Describe how i	njury occurred	
İSİ	Attending ir death. ector: After by the funer	icat	2 Accident investigation 3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm,			Location (Stree	at and Number	or Rural Route Number,
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	Hospital or 24 hours afte Funeral Dir tely filled in I		29a. Certifier Certifying Physician: To the best of my knowledge, de					
	To the Hospitai or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only one) Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my op	pinion, death occurred a	at the time, date	and place, and	due to the cause(s)
_	Veith veith con con	Σ	29b. Signature and title of certifier	29c. License	1 1 0	29d.	Date signed (A	Month, Day, Year)
)		1 90/		66912		7/	1/10
	3		30. Name and address of person who completed cause of death (Item 23a) (Typ		·			
	Sta	to	Venkata J. Parsa. M.D. 602 St. 31. Date filed (Month Day Yal) 1. Registrar's Signature	Atwood R	d.,Ste.20	00,Bel	Air,	MD 21014
	Sta Registra	ar	SEP 2 8 2010 Census B. A.	31500				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 2่ดีโก Dorothy Jewe1 Eldreth 21:15 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital E1kton Ceci1 If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Yes 1 □ M 2 💢 F Months Days Hours Min. 216-28-8590 Kentucky Director 80 Nov. 929 Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 421 Elk Mills Road 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married Maryland \$1215-0036 Completed by Yes 2X No perriit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", If Yes, Give 1 ☐ Yes 2 X No Specify. 3 ☑ Widowed 4 ☐ Divorced Specify White Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker In her own home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Irvin William Halcomb Rose Marie Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne R. Eldreth, Sr./Son 76 Lee Drive, Elkton, MD 21921 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September Cherry Hill Methodist Cem. 24 Cherry Hill, MD 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of). cause. Enter Underlying Examir Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Dav Year detached the 9 Unknown s been signed by t. should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an has page 2 autopsy prior to completion of cause of death? this certificate 2 No Yes Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? မြ 1 Yes 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify funeral Certificate: . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After To the mosp.....
within 24 hours after death.

To the Funeral Director: Aft 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Priffying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and titl 29d. Date signed Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Gloria Simonson,

31. Date filed (Month, Day, Year)

MD

32. Registrar Signature

133 N. Bridge St., 3rd floor, Elkton, MD

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed. Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Barton M. Eckert / Son	12 Farm Haven Cou	rt, Rockville, Maryla	nd 20852
20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - Cit	or Town, State
1½ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Montefiore Cemetery	9/19/2010 Abington	Township, PA
21. Signature of Funeral Service Licensee MCGKENNUT MOIS 97	22. Name and Address of F	dward Sagel Funeral D Pike, Rockville, Mar	irection, Inc.
resulting in death) Due to (or as a company)	ne death. Do not enter the mode of dying, such ners Dementia consequence of): 7 Artery Disease	as cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
Sequentially list conditions, that y leading to mediate cause. Enter Underlying Cause (Disease or injury that initiated events			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 □ 4 □ Pregnant at tire 9 □ Unknown	☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date o Month	f delivery Day Year
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25. Was case referred to medical	26 Pl	1 ☐ Yes 2 √ No 1 ☐ ace of Death (Check only one)	Yes 2 😾 No
examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	Other:	Nursing Home 5 Residence 6 Other	Specify)
27. Manner of Death 1 ★ Natural 5 Pending 2 △ Accident investigation 28a. Date of Injury (Month, Day, Y	28b. Time of 28c. Injury at	28d. Describe how injury occurred	- County
3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (- At home, farm, street, factory, office (Specify)	28f. Location (Street and Number of City or Town, State)	r Rural Route Number,
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29b. Signature and title of certifier	29c. License numbe D56345	29d. Date signed (N September	
30. Name and address of person who completed cause of deat	, , , ,		
Piyush Pate1, MD 19745 Execu		mantown, Maryland 208	74
31. Date filed (Month—Day, Year) SEP 14 2010 32. Registrar's	S. Jacks		

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ERALDINE 0730 M WARDS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPICE HOUSE MANDRIN ANNE ARUNDEL HARWOOD 8. Date of Birth (Month, Day, Year, AUGUST 27 If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 M 2 F Director Yrs 150-32-2537 NORTH CAROLINA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f 1 X Yes 2 No MD PRINCE GEORGE'S UPPER MARLBORO 5 10e. Street and Number 10g, Citizen of What Country? 23a Funeral 15905 CHIPPENHAM TERRACE USA 20774 items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. traumatic event, the Medical Examiner Armed Force Black, White, etc. 0 Completed by and 2 should be filed within 72 hours after of Health and Mental Hygiene.

tem 27 is marked other than "natural", or 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: BLACK 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) BOOK BINDING GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HARRY HARPER HELEN PRIDGEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 TRACY EDWARDS/SON 3705 PAXMORE COURT UPPER MARLBORO, MARYLAND 20772 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place HARMONY CEMETERY 9/17/2010 LANDOVER, MARYLAND J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. ist only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death ANCREAS Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Box 68760 the as IF FEMALE; use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? jo Month Day Year 5 Other (specify) Pregnant at time of death the 9 Unknown P.0. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed' 1 🗌 Yes 2x No Yes 2 No **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Other: 1 Tyes 2-No Spire ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 1+0415 Certificate: 28b. Time of 28d. Describe how injury occurred hin 24 hours after death.

the Funeral Director: After

mpleted filled in by the funer 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of Pertific ZIM Name and address of person who completed cause of death (Item 23a) (Type, Print) EYENSE HIGHWAY NNAPOLIMPINYO YILLFIATE

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

10-07040 James Egerson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Amend 18 per FD, DOR, Registrar 9/16/10 LDR, Registrar 9/16/10 LDR	J 30512
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Wedical Exami	Hei	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of De	0133 hrs
		Cheston Lane Wye Mills Queen Anne	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9.	
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or ite	-un	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as sta (check only 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as sta (check only 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as sta (check only 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as sta (check only 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as sta (check only 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of t	
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5x1	1	30. It is address of person who completed cause of death (Item 23a)	
\ "		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 1- State Registrar #31, per schd, 9/10/10 ca Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Dav **Physician** 825 M Sept 2010 WI /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rehab + NUISING CHE 100 MICO 7. Age (In yrs. last birthday) If Under 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) Year **Funeral** Months Days Hours Min. 217-26-596 118/1923 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show 1 Yes 2 No ANNE SOMERSE ns 23a or 28a-f sh must be notified Director RINCESS 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United STREET 2185 3040 or items 23a Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Examiner. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WhitE Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Flect-RONICS Baltimore, Maryland 2121 1 and 2 should be filed within Elementary/Secondary (0-12) College (1-4or 5+) ectronics ے سے 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Princess 21853 ANNE Md. Ebu)05E 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State UINTON CEMETER 4 ☐ Donation 5 ☐ Other (Specify) FUNERAL 21. Signature of Funeral Service Licensee Home M00295 Arme, Md Somerset 11673 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner 00 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Dav in the past 12 months?
1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. I detached cate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 3 Probably 4 □Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' 2 No 2. 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1/ Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 16 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 ObINSON lillam 31. Date filed (Month, Day, Year) 804 9/10/2010 Registrar

			For State	State	of Maryland					and M	lental Hy	gien	e ₂ n		30514
			Registrar			Cer	tificate	of L	eath			Reg. N	10.	10	30317
Ħ	Physici Medi		1. Decedent's Name (First, Midda Alice France:		ald						2. Date of De Septen		Day 12,	Year 2010	3. Time of Death 11:45 a M
	Exami		4a. Facility Name (if not institution	n, give street and nur	nber)		4b. City,	Town, or	Location of	f Death		4	c. County	of Death	
1	<i>?</i>		Holy Cross Ho	spital				Sil	lver S	Sprin	ng		Мо	ntgo	merv
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday)	If Under Months		If Under		8 Date of Bir	th		9 Rinthr	lace (State or Foreign
	Director	١.	578-18-1006	1 □ M 2 x JF	90	Yrs.	Months	Days	Hours	IVIII I.	May 3), '°1'	920	Coarn	D.C.
•	T MO	٦.	Usual Residence of Decedent		10 00 7						_				
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medi-al Examiner must be notified at , the Medi-al	Funeral Director	10a. State 10b. Count	Montgomer	10c. City, T		cation hersb	11.250							0d. Inside City Limits 1 ☐ Yes 2 ※ No
	r 28g	<u>Pire</u>	10e. Street and Number	Montgomer	У	Gait	10f. Zip					10- (Citizen of I	What Coun	
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	ath w	nue	11. Marital Status		edent Ever in U.S.	13.1	Mas Decede			ain? (Sne	cify Yes or No-		USA	e - Americ	an Indian
	r deg	by Fi	1 Never Married 2 Ma	Armed Fo		13.1	f Yes, speci	ify Cubar	n, Mexican	, Puerto	Rican, etc.)			ck, White, e	
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Maryland	≥ ≥ ∽ ⊐		19a. Informant's Name/Relation Frederick Mic			19b. Mailir					ane, G				ode) MD 20882
	i and 2 sl of Health a item 27 i		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Nam		1		Date	_		City or To	
Baltimore,	int of t: If it		1 K Burial 2 Cremation		State cem	etery, cren	natory or ot Heave	her place		Se	pt 16				ng, Marylar
Ē	permit. Page Department o Important: If any injury or once.		4 Donation 5 Other 21. Signature of Funeral Service		Juan						2010				197 11417141
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			23a. Part 1. Enter the disease, of	or complications that	caused the death. [ver_s	princ	Approximate
			shock, or heart failure. List	only one cause on ea	ach line.			or dying	g, 50011 00 1	bar diac o	, reopiiatory a	,,,,,,			Interval Between Onset and Death
	Physician/ Medical		disease or condition resulting in death)	a	ration Pn		nia								
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		ē	Sequentially list conditions,	b. Due to	(or as a consequen	ice of):									
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s, l	ires 1 sign Id be	Completed by	Dehydration,	Poor Oral	Intake,	Urina	ary Ti	ract	Infe	ctic	n 1 🗆	Yes	2 🗌 No	3 🗆 Prob	ably 4 X Unknown
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Division of Vital Records,	or Attendate after death Director: /		4 ☐ Homicide deter	mined buildi	ng, etc. (Specify)	, ,					City or To				,
L	To the Hospital or Attending Physician: The law requires that the death certificate be execuiting 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician a completed filled in by the funeral director, page 2 should be detached for use as the burial-time.	Medical		g Physician: To the b											
	n 24 n 24 ie Fui	Jed	(Check 2 Medical		sis of examination ar	nd/or invest	tigation, in n	ny opinio	n, death oc	curred at	the time, date	and plac	ce, and due	e to the cau	se(s) and manner stated
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	8			otha		MIL	D.	D6	4100			Se	ept.	13, 2	2010
	le		30. Name and address of person	who completed caus	se of death (Item 23	Ba) (Type, F	Print)								
			Dr. Smitha Bh					Len 1	Road,	Sil	ver Sp	rinc	, MD	2091	.0
		4													

DHMH 17 Rev 7/2009

Registrar

			1 - For State Registrar		State of Ma	ai yiai i	-	tificate of				Reg. No.	2010	31	0515
	Physicia	nn/	1. Decedent's Name (First	st, Middle, Las	t)						2. Date of De Month	ath		3. T ir	me of Death
	Physicia Medio		Leslie		Ferrine						Augus	Day		0 9	:11P M
	Examin	ner	4a. Facility Name (if not in		•	1		4b. City, Town,					County of Dea		
	Funeral		Clinton 1 5. Social Security Number	Nursin er 6. Se			Center ast birthday)	If Under 1 Year	into:	n der 24 Hrs.	8. Date of Birt		rince		rges tate or Foreign
	Pirector		239-40-94	404 I	M 2 □ F		9 Yrs.	Months Day	s Hour	s Min.	(Month, Da Feb. 2	y, Year)	Co	nuntry)	
ρι	how] _	Usual Residence of Dece 10a. State 10b	edent . County		10c. Cit	y, Town or Loc	ation						10d Insid	de City Limits
larylar	a-f sl	ecto	MD	-	PG	1001 011		inton							Yes 2 No
the M	or 28 e not	直	10e. Street and Number		FG			10f. Zip Code				10g. Citiz	en of What C	1	
with	s 23a rust b	Funeral Director	9211 Stua	art La	ne				207	35		Un	ited :	State	es
death	r item iner n		11. Marital Status		12. Was Decedent E Armed Forces?		S. 13. W	as Decedent of Yes, specify Cu	Hispanic ban, Mexi	Origin? (Sp can, Puerto	ecify Yes or No- Rican, etc.)	1	4. Race - Ame Black, Whit		ın,
5-0030 hours after	al", o Exam	d by	1 ☐ Never Married 2 3 ☐ Widowed 4 🙀		1 Yes 2 1 If Yes, Give Year or Dates.	No	1	☐ Yes 2 🔀 N	lo Spec	cify:		s	pecify: Bla		
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ary thould	and wis ma		19a. Informant's Name/F	Relationship (Ty	rpe, Print)		19b. Mailing	g Address (Stree	et and Nun	nber or Run	al Route Numbe			p Code)	
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cuted	nd ransit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	· 5	C										
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cate b	physi the b	Nedical			d										
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death	ed by the attending pretached for use as	Physician/N	in the past 12 month 1 Yes 2 No		4 Pregnant at			Other (specify)	ncy				Month	Day	Year
at the	d by the		9 Unknown Part II. Other significant	conditions co		ıt not resi	ulting in the un	derlying cause	given in Pa	art I.	23e Did to	pacco us	e contribute to	the cause	of death?
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Ordo,	s beer shou	olete	- De	mentu	e renal					L	24a. Was	an	24b. Were au	topsy findi	ngs available
The lay	ate has	Completed									autop perfo 1 🗌 Yes	rmed?	death?	completion s 2 1 No	of cause of
ian:	ertifica ctor, p		25. Was case referred to examiner?	_				26.	Place of D	eath (Checi		2 110		3 2 3 140	==
Physic	this or al dire	은	1 Yes 2 No	-			ER/Outpatient	3 L DOA			ome 5 Resid			ify)	
ding L	After	Certificate:		Pending Investigation	28a. Date of injur (Month, Day,		28b. Time of injury		ıry at rk? ☐ Yes 2		28d. Describe h	ow injury (occurred		
Atter er dea	ector by the	rtifi		Could not be determined	28e. Place of Injur					- 100	28f. Location (S		Number or Ru	ral Route N	lumber,
ital or	ral Dir led in			/	building, etc.						City or Tow				9
Hosp 24 hou	To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 □ M	ledical Examir	ician: To the best of r ner: On the basis of ex	amination	and/or investig	ation, in my opir	nion, death	occurred at	t the time, date a	nd place, a	nd due to the	cause(s) and	d manner stated.
To the	Fo the	Σ	only one) 3 ☐ C 29b. Signature and title of	f certifier	e Practioner: To the b			29c. Licen	se numbe	r		29d. Date	signed (Mont)	h. Dav. Year	r)
			•	\mathcal{R}	Smide	ر به ز		D	006	6/6/4	-	Sep	lember	Rnd	,200
2 1	2		30. Name and address of	person who co	Smalus of de Nani, M.	ath (Item	23a) (Type, Pri	int)	Λ.						
_ 0	~		Kavi Si 31. Date filed (Month, Day	ndhy	Jani, M.	D., (o Pos	st off	ice	#1	01, Wa	ald o	rf, M	D.2	0602
	Stat	ie ar	CED 1 Q 20		32. Registrar	s sign it	and I								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Felipe sept.12,2010 Year Physician/ Rosario Nereyda Amparo 3:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery General Hospital Olney 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Country Rep. of Days 1 🗆 M 2 🔀 Months 052-36-4676 Hours 2927771937 Director Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If fiem 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must he matified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Olney 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Rep. of Dominican 20832 3230 St.Augustine Court 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married 1 M Yes 2 □ No Specify: Rep. of þ Baltimore, Maryland 21215-0036 Specify: Black If Yes Give 3 Widowed 4 Divorced Completed Dominican Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)
Owner-Operator (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Store 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maria Felipe Luis Rosario Address (Street and Number or Rural Route Number City or Town, State, Zip Code)

St. Augustine Ct. Olney, Maryland 20832 19a. Informant's Name/Relationship (Type, Print) Maria E.Guzman/Daughter L^{20c.} Location - City or Town, State Los Girasoles, Rep. of Dominican 20a, Method of Disposition 20b. Place of Disposition (Name of 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Cristo Redentor 9/20/2010 PHIME ADDROUGH SERVICE, P. A 21. Signature / Funeral Ser 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PSI Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner OVARIAN CANCER MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Lirector Atter this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🖰 No 3 🗌 Probably 4 🗆 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Hospital: ျှ 1 Main Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? iniury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 | 3 | only one)

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 5 2010

Dhai

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUMALATHA DHANIREDDY, MONTGOMERY GENERAL HOSPITAL, OLNEY

MD

32. Registrar's Signature

29c. License numbe

D 70998

29d. Date signed (Month, Day, Year)

SEPTEMBER, 12, 2010

			For State of M State of M Registrar	aryland / Depa	artment of He tificate of De			iene 2010	30517
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				Date of Death Month	h Day Year	3. Time of Death
	Medic Examir	al	Lyda Louise Fleming 4a. Facility Name (if not institution, give street and number)	3	4b. City, Town, or L	ocation of Death	Septemb	<u>er 16 201</u>	<u>0 0750 ^M</u>
			Dorchester General Ho		Cambr:	idge		4c. County of De Dorc	
п	Funeral Director		5. Social Security Number 213-22-8717 6. Sex 1 M 2 🖫 F 7. Ag	e (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, NOV • 24	^{Year} 1924 Ma	Birthplace (State or Foreign Bountry) aryland
	and show Lat	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
Q	Maryland 28a-f sho notified at	irect	MD Dorchester		Cambr	idge			1 🗆 Yes 2 🏝 No
Z	death with the items 23a or ner must be n	Funeral Director	10e. Street and Number 5017 Drawbridge Road		10f. Zip Code	21613	1	0g. Citizen of What 0	Country?
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent: Armed Forces? 1 Yes 2 Wifeld Forces? 1 Yes 2 Wifeld Forces?	.No	Vas Decedent of Hisp i Yes, specify Cuban, Yes 2 X No	Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, nite, etc. white
21215-0036	within 72 hou giene. er than "natu ; the Medic al	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 9)	(Give I	lent's Usual Occupat kind of work done du O NOT use retired) homemak	ring most of work	ing	16b. Kind of Busines	
Maryland 2	d be filed w Mental Hyg arked othe	To Be	17. Father's Name (First, Middle, Last) Edward Elliott				e (First, Middle, M Travers	laiden Surname)	
	and 2 shoul Health and I tem 27 is m		19a. Informant's Name/Relationship (Type, Print) Sharon James daugh		g Address (Street an Maple Dam			City or Town, State, 2	
Baltimore,	Page 1 an nent of He a nt: If iter ary or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		sition (Name of natory or other place) er Mem. Pa	1	Date 20/10	20c. Location - City of	
Baltir	permit. P Departme Importar any injur		21. Signatur Funeral Service Licensee		Name and Address 700 Locus	of Facility Th	omas Fur	neral Home	P.A.
	Pttysician/		23a. Part Enter the disease, or complications that causes shock, or heart failure. List only one cause on each line Immediate Cause (Final	е.	r the mode of dying,	such as cardiac o	or respiratory arres	· · · · · · · · · · · · · · · · · · ·	Approximate Interval Between Onset and Death
€	Medical Examiner		resulting in death) Due to (o as	a consequence of):	gitation	ai lure			104ens
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequence of):	,	n - Sev	ere.		5 40005
	kecuted n and al-transi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as	Abrili a consequence of):	atron				15 years
092	cate be executed physician and the burial-transit	edical	La Jour	e renal	failu	re			5 days
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi.	Σ∣	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
, P.O.	gned by	by Pr	Part II. Other significant conditions contributing to death b	- 1	1				to the cause of death?
ords	require been si should	leted	Chronic Kidney dise.	ose, riga	extension	? /	1 ☐ Ye		Probably 4 Unknown autopsy findings available
Rec	The law ate has page 2 t	Comp			-		autops perform	y prior to ned? death?	completion of cause of
/ital	s ician: The la certificate ha irector, page	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 → No Hospital: 1 →			e of Death (Check		7	
Division of Vital Records,	nding Physath. r: After this e funeral di	Certificate: To	27. Manner of Death 1 Natural 5 Pending (Month, Da) 2 Accident Investigation		28c. Injury a work?	4 L Nursing Ho	me 5 ∐ Resider 28d. Describe hov	nce 6 Other (Spe w injury occurred	ecify)
Division	tal or Atters after de al Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inj building, etc	ury - At home, farm, stre c. (Spec <i>ify</i>)	et, factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director, After thi completed filled in by the funeral	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of 2 Medical Examiner: On the basis of e	xamination and/or invest	igation, in my opinion,	death occurred at	the time, date and	d place, and due to the	e cause(s) and manner stated.
	Note to the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total of the total		29b. Signature and title of certifier And THI TO A A AND AND AND AND AND AND AND AND AND	on alu	29c. License n			ed. Date signed (Mor	
	\mathcal{A}		30. Name and address of person who completed cause of d	eath (Item 23a) (Type, P	rint) 5+	Cam	bndst	9/16/10 MD.	
ı	Stat Registra	_	31. Date filed (Month, Day, Year) 32. Registra	ar's Sign ture	the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s				

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1	Stat		VICTOR ONYES 31. Date filed (Month, Day, Year) SEP 1 3 2010	completed cause of death (Item IAFA 7325A H 32. Registar's Signate		LARENT	ty GRE	Erebeet	MARY	LANCE	0 20+70
20	8		30. Name and address of person who	completed cause of death (Item	23a) (Type, Pi	rint)					
	7 0 0 0 0		29b. Signature and Wile of certifier	Ke MO		29c. License	number	1	29d. Date signe		Day, Year) 7, 2010
	the Hosl hin 24 ho the Fune npleted f	Medical	(Check 2 Medical Exa only one) 3 Certifying No	nysician: To the best of my knowle miner: On the basis of examination urse Practioner: To the best of my	and/or investi	gation, in my opinior eath occurred at the	n, death occurred a time, date and plac	t the time, date and the to the	ind place, and du e cause(s) and m	ue to the cau nanner as sta	use(s) and manner stated. ated.
DIVISION	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		4 Homicide determine	d 28e. Place of Injury - At nor building, etc. (Specify)				City or Tow			
ouois	ttending death. tor: After the funer	Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigati 3 ☐ Suicide 6 ☐ Could not	(Month, Ďay, Year)	injury		et Yes 2 □ No		low injury occur		
or vital	Physic this ce	၉	examiner? 1 Yes 2 No 27, Manner of Death	Hospital: 1 Inpatient 2 Inpat	ER/Outpatien		4 ☐ Nursing Ho)
당	ian: Th intificati stor, pa		25. Was case referred to medical examiner?	1		26. Pla	ce of Death (Chec		2 🛣 No	1 Yes	2 □ No
Records,	ne law re e has be ige 2 shr	Completed							osy ermed?	prior to col death?	psy findings available mpletion of cause of
ds, r	equires the en signe ould be c	ted by			-	, ,					pably 4 Unknown
7.0. B	at the design the design the detached		9 ☐ Unknown Part II. Other significant conditions	9 🗌 Unknown		11 37	en in Part I.	23e. Did to	obacco use con:	tribute to th	ne cause of death?
BOX 68	attending for use a		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	23c. If yes, outcome of pregnar 1 Live Birth 2 Fetal 4 Pregnant at time of de	Ideath 3 🗌	Ectopic pregnancy Other (specify)	/			ate of delive	ery Day Year
2/60	ficate be g physic is the bu	fedical		d							
	cate be executed physician and the burial-transit	al Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a consequent		resc ble	DUNG				
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequent	ence of):						
m of	Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ	ence of):	TFARCT I					
	Physician :		23a. Part 1. Enter the disease, or co shock, or heart fallure. List only Immediate Cause (Final	mplications that caused the death one cause on each line.			, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
ра	perm Depa Impo any ii	a l	21. Signature of Funeral Service Lice	2 L. Woods	7 4	Arshdides 217 9th S	St. N.W.	Washin	gton, D	C 200	011
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once.		1 X Burial 2 Cremation 3 4 Donation 5 Other (Spe	Removal from State control Roc	_{emetery, crem} k Cree	k Cemeter	y 9-11	-2010	Washin	•	
e, ⊠	and 2 s Health Item 27		Crystal Fletch 20a. Method of Disposition	20b. Pl	lace of Dispos	Butterwon	!	Largo _{Date}	MD. 2		own. State
aryi	should be and Me		William Werts 19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Street a	Verda Ro		r, City or Town,	State, Zip C	Code)
and	be filed vental Hyg ked othe	To Be	17. Father's Name (First, Middle, Las		55015		18. Mother's Nam	e (First, Middle,			
2121	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Completed	(Specify only highest Elementary/Seconday (0-12)	grade completed) College (1-4 or 5+) 1 yr.	(Give k life. DC Secre	ind of work done d DNOT use retired) tarv	uring most of work	_	US Coas		
2-00	hours a natural' lical Ex		3 XWidowed 4 Divorced	If Yes, Give Year or Dates.	16a. Deced	ent's Usual Occupa	ation		Specify 16b. Kind of E	v: Bla Business Inc	
9	fter deat , or iten aminer r	by	11. Marital Status1 ☐ Never Married 2 ☐ Married		If	Vas Decedent of His Yes, specify Cubar	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Bla	ce - Americ ick, White,	etc.
	h with ti ns 23a c nust be	Funeral Director	600 Largo Rd.			20774			USA		
	he Mary or 28a-f notifie	Direc	MD Prince 10e. Street and Number	Georges Lar	go	10f. Zip Code			10g. Citizen of	What Cour	1 🗆 Yes 2🛣 No
	land show dat	tor	Usual Residence of Decedent 10a, State 10b. County	10c. City	y, Town or Loc	ation				1	Od. Inside City Limits
	Funeral Director		382-20-6683	Sex 1 M 2 X F 7. Age (In yrs. la 84	est birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Dec. 25	th y, Year 1925	9. Birthp Coun	place (State or Foreign try) SC
م		er	Washington Adve	ntist Hospital		Takoma	Park	To be a source	Mont	gomer	-
	Physicia Medic Examin	al	LOIS GIL 4a. Facility Name (if not institution, gi	BERT		4b. City, Town, or	Location of Death	SEPT	Pay 4	2010 y of Death	1830 ⋈
	· ·		Registrar 1. Decedent's Name (First, Middle, L		Cer	uncate or L	eam	2. Date of Dea	ath		3. Time of Death
			For State	State of Maryland	a / Depa	tificate of F	leaith and i	лептат ну	glerie 2 f	111	30518

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygien [2] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Johnny W. Gayden Sept. 12 20 1 20 1 20 1 8:55P /Medical 4a. Facility Name (If not institution, give street and number) 107 Swan Creek Road 4b. City, Town, or Location of Death Fort Washington $^{\mbox{\scriptsize 4c.}}$ County of Death P , G , Examiner 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | 9. Birthplace (State or Foreign Country) | 73 | Yrs. | Months | Days | Hours | Min. | Sept 12, 1937 | Northcarolina 5. Social Security Number **Funeral** 6. Sex 1**₩** M 2□ F 244-58-7866 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itame 23s ~ ~ ~ once. 10a. State Md. 10c. City, Town or Location Fort Washington 10b. Count 10d. Inside City Limits P.G. 1 No 2 No Director 10e. Street and Number 107 Swan Creek Road 10g. Citizen of What Country? 10f. Zip Code 20744 U.S.A. Funera 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) D.C. Housing Elementary/Secondary (0-12) College (1-4or 5+) Mechanic 9th Authority 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Waddell Gayden Azzilee Johnson P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Gwendolyn Johnson Gayden 107 Swan Creek Road Fort WashingtonMd.20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State Chesapeake Cremat Sept20,10 Beltsville, Md. place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wash., D.C. 20001 Robinson Funeral Home 1313 6th StN.W. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enley the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Metastatic Soft Tissue Sarcoma years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner sicien and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de. 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death signed by the at the detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 1 Yes 2**√** No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ☐ Nursing Home 5XI Residence 6 ☐ Other (Specify) 1 ☐ Yes 2X No Certification: To 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death 1 ☐ Yes 2 ☐ No · М safter death 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hoapital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) MD 10200 Sept.14,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington, D.C. Dennis Priebat, MD Washington Hospital Center CancerCenter 110Irving 32. Registrar's Signature 31. Date filed (Month, Day, Young) Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death September 10, Physician/ Margaret B. Graham 2010 7:55 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sacred Heart Home Hyattsville Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Davs Hours 017-14-6641 1920 Medford, MA 89 Director December Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland items 23a or 28a-f sho ner must be notified at Director 1 X Yes 2 No Hyattsville Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 4909 42nd Avenue 20781 permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 Married δ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Anna Gertrude Hanley Hugh Angus MacDougall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David L. Graham / Son 15257 Robinson Drive, Milton, DE 19968 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 9/15/2010 Alexandria, Virginia Metropolitan Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 4739 Baltimore Avenue 22. Name and Address of Facility Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Respiratory Failure Medical resulting in death) Due to (or as a consequence of): **Examiner** Years Chronic Obstructive Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami anding physiclan and use as the burial-transit Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter in the past 12 months?
1 Yes 2 No jo Pregnant at time of death 5 Other (specify) i signed by the at Id be detached fo Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Osteoporosis Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24 hours after death.

2 Hours after death.

E Funeral Director. After this certificate has been sive funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dementia autopsy performed?

1 Yes 2 No Atherosclerotic Heart Disease 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Hospital: 2 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? _1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 🔀 Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

Raman R. Tuli, 10810 Darnestown Road, Suite #202, Gaithersburg, MD 20878 31. Date filed (Month, Day, Yea SEP 1 8 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

only one)

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

9/14/2010

29c. License number

State

Registrar

FISEHATSION

SEP 1 8 2010

31. Date filed (Month,

MEHARI

MD

32. Registrar's Signature

2010

SEPTEMBER

MEDICAL CENTER DRIVE ROCKVILLE MD

20850

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 30522 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month, 3. Time of Death Day Physician/ Jeanette Goines 06:15 AM 2010 cotemb Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown Northwest Hospital 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Jan 27, **Funeral** 1 □ M 2 🏝 F Months Hours Min. Jan. 1942 DC **Director** 577-56-4158 68 Usual Residence of Decedent a or 28a-f show be notified at 10a. State 10d. Inside City Limits the Maryland 10c. City, Town or Location Director 1 X Yes 2 No Fort Washington Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b. Funeral United States 20744 10800 Indian Head Hwy, # B-18 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African 1 Yes 2 No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Private Claims Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Freeman Rose Banks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rose Freeman/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Sept. 16, 1 🖾 Buriai 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Lincoln Cem. Suitland, Maryland Sign Mame and Address of Facility Stewart Funeral Home, ture of Funeral Service I censes Washington, DC 20019 Benning Road NE Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, one art failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final a. Acute Physician Cerch rovalcular disease or condition resulting in death) day Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the defendence as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth
4 Pregnant a
9 Unknown 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death ☐ Yes 2 No g Unknown is certificate has been signed by director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) In Pt Hospite 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation 6 Could not be Accident ☐ Accider 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check з 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day

6 2010

Mp

32. Registrar's Signatur

34 Aviata Blud 21061 Clen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 | 0

			For State Registrar	State of Maryla		tificate of D			Reg. No.2 (010	30523	
	Physicia		1. Decedent's Name (First, Middle, Last, JONATHAN RICE					2. Date of Dea	uth 21 , 201	1 O ^{Year}	3. Time of Death 12:20 P M	
-	Medic Examin						Location of Death		4c. County of Death			
yame 1			9308 BROOKWOO		E PLAIN			RLES				
	Funeral Director		5. Social Security Number 6. Sec. 577-42-1221	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti 2 – 1 2 –	1 ⁷ 934	g, Birthp Coun N • C	olace (State or Foreign try)			
	iryland I-f show ied at	Director	Usual Residence of Decedent 10a. State MD • CHARLE		City, Town or Lo	cation HITE PL	AINS	-		1	0d. Inside City Limits 1 ☐ Yes 2 🏿 No	
	h the Ma ka or 28a be notif	al Dire	10e. Street and Number		· · · · · · · · · · · · · · · · · · ·	10f. Zip Code			10g. Citizen o			
	eath wit tems 2: er must	Funeral	9308 BROOKWOOD	12. Was Decedent Ever in	U.S. 13. V	2069.	spanic Origin? (Spe	cify Yes or No-		ace - Americ		
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If then 27 is marked other than "natural", or items 28a or 28a-f show minoriant: If then 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Never Married 2 【XMarried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates.	1	f Yes, specify Cubar I ☐ Yes 2 ☐ X No		Rican, etc.)		lack, White, o		
21215-0036	in 72 hou e. nan "natu Medica	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)		(Give I	dent's Usual Occupa kind of work done di O NOT use retired)	uring most of worki	ng	16b. Kind of			
	led within Hygiene. other tha ent, the N	Be C	10th 17. Father's Name (First, Middle, Last)		MAS	TER CAR	18. Mother's Name	/First Middle	SELF		OYED	
/lanc	should be filed within 73 and Mental Hygiene. 7 is marked other than raumatic event, the Me	일	CHESTER ARTHU	R HASH				LIZZI				
	12 should alth and half alth and half art is me or traume		19a. Informant's Name/Relationship (<i>Tiy</i> p MARY HASH-SPOU			_	nd Number or Rural Route Number, City or Town, State, Zip					
Baltimore,	Page 1 and nent of Heal ant: If item 3 ary or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 One Donation 5 Other (Specify		o. Place of Dispo cemetery, cren			Date 3 - 1 0	20c. Location	,	, , , , , , , , , , , , , , , , , , ,	
Baltir	permit. Page Department (Important; II any injury or		21. Signature of Fureral Service License			Name and Addres AYMOND I A PLATA						
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	ications the caused the decause on each line.							Approximate Interval Between	
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cons		21				_	Onset and Death	
	Examiner	i.	Sequentially list conditions,	choon		7740	ad L	ente	er-	_		
	outed nd ransit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
0	cate be executed physician and the burial-transit	Medical E	resulting in death) Last	Due to (or as a cons	equence of):							
68760	rtificate ing phy e as th	Med	IF FEMALE:	3c. If ves, outcome of pred								
Box (Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director, Fether this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	у		23d. E	Day Year					
, P.O.	ires that the dea signed by the a Id be detached f	Ď	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	inderlying cause give	en in Part I.	100			he cause of death?	
of Vital Records,	require been si should	Completed						24a. Was	an 24b	o. Were auto	psy findings available	
Rec	The law cate has page 2.	Comp						autor perfo 1 🗌 Yes	rmed? 2 No	prior to co death? 1 Yes	empletion of cause of	
tal	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:		26. Pla	ace of Death (Check					
fΝ	Physi this c	<u>و</u>	1 Yes 2 100	1 Inpatient 2 28a. Date of injury	ER/Outpatier	nt 3 🗆 DOA	4 U Nursing Ho	ome 5 Resid			2	
o uo	ending l sath. vr: After ne funer	Certificate:	1-Natural 5 Pending 2 Accident Investigation	(Month, Day, Year,		work		zod. Describe II	ow injury occi	med		
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu		3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe		eet, factory, office		28f. Location (S City or Tow		nber or Rura	l Route Number,	
	the Hospit thin 24 hour the Funera mpleted fills	Medical	(Check 2 Medical Examir	ician: To the best of my kn ler: On the basis of examina Practioner: To the best o	ation and/or invest	tigation, in my opinio	n, death occurred a	t the time, date a	nd place, and o	due to the ca	use(s) and manner stated.	
	To the Complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex	_	29b. Signature and title of certifier	t		29c. License	F35)		29d. Date sign	ned (Month,	Day, Year)	
			30. Name and address of person who co	ompleted cause of death (I	tem 23a) (Type, F	Print) Pla	ja	Ms)) (> 640	6	
	Sta	e	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature 1	backet	<u></u>	·				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 30524 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death spotembe 18 35 **Physician** /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year)
Oct. 24, 1 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 XM 2 □ F 1942 Boston, MA 67 033-30-4812 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland works 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Annapolis 1 X Yes 2 □ No Maryland Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code United States 33 Chesapeake Landing 21403 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status event, the Medical Examiner filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 ō white 1 ☐ Yes 2X No Specify þ 3 ☐ Widowed 4 ☐ Divorced natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Indiana University 5+ Associate Dean 18. Mother's Name (First, Middle, Maiden Surname) Definit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Evelvn Borstell George Hoffstein မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4127 - 21st Road., N., Arlington, VA 22207 Lita Miller, Daughter Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Garden 09/12/10 Falls Church, VA 21. Signature of Fu, con Service Lic risee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Seter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEDSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): myelogenous leukemia **Examiner** Securitally list our Wine Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No ō Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð page 2 should be 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?/ Ves 2 VNo 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one, Be examiner? Hospital: 1 1 Inpatient Other: 4 \sum Nursing Home 5 \sum Residence 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 6 Other (Specify) မ after death.

Director: After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manyler of Death Certification: 17 Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie RES-000 ĺθ Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Greenberg

Keiko

31. Date filed (Month, Day, Year)

SEP 14

parked

Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 09707/2010 0030 WILFORD R. HENSON Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Rockville 0 If Under 1 Year If Under 24 Hrs. Social Security Number Sex 1X M 2 D F 8. Date of Birth Funeral Hours 09/21/1957 2010 Director 565-94-8000 52 Usual Residence of Decedent 10b. County 10c. City, Town or Location Director "natural", or items 23a or 28a-f sl MD Rockville Montgomery 10e. Street and Number 10f. Zip Code September Funeral USA 506 First Street 20850 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed ... and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Butcher Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) Rachael Davis James Henry Henson Henson 19a. Informant's Name/Relationship (Type, Print) Aaron Henson - son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State Ardent Cremation Sv 09/14/10 4 Dopation 5 Other (Specify) 21. Signatu Funeral Service Licens 22. Name and Address of Facility 23a. Part 1. Enter the disease or complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final CIVINDS15 Pnysician/ IVer disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** astritis Sequentially list conditions. Examine if any leading to immedicause. Enter Underlying attending physician and for use as the burial-transit oneu monia Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant a Pregnant at time of death 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. coaqu lopathy clostridium ascites throm bocytopenia 24a. Was an autopsy performed? Yes 2 X No After this certificate has funeral director, page 2 effusion 25. Was case referred to medical examiner? Be completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑Wo မ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work / 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) Medical 29a. Certifier (Check within 2 To the I 29b. Signature and title of certifier 29c. License number þ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janelle

4c. County of Death Montgomery 9. Birthplace (State or Foreign TX 10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country? 14. Race - American Indian Black, White, etc. Specify: Black 16b. Kind of Business Industry Giant Food 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7035 Brecken Place, Lithonia, GA 30058 Hanover, MD Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 Approximate Interval Between Onset and Death 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practice of Tails 5 at all my monledge of all construct at the time, date and place, and due to the cause(s) and manner stated. medical Williams, M.D. Drive 9901 31. Date filed (Month, Day, Year) **ORIGINAL**

3. Time of Death

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State

14

Devorn Markell Haynes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 30526 State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No.							
Physician/ Medical Examine		Decedent's Name (First, Middle,Last)	Markel	1 Hal	(12.0 C	Date of Death Month	n Dav Year	3. Time of Death 1342 hrs	
		4a. Facility Name (if not institution, give st		/ /74.9/ 4b/Ci	ty, Town, or Location of De	September eath	4c. County of Death		
\{		Easton Memorial Hospital		Ea	ston		Talbot		
Funeral Director		0.70.00.007	7. Age (In yrs. I		Under 1 Year If Under 24 Onths Days Hours M	Min	h(MM/DD/YYYY) 9. Bird Foreig Cou	hplace (State or n Movy land untry)	
any		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits	
*	'n	MD Talbo	+	Cordov	a			1 Yes 2 No	
Maryla 28a-f	Director	10e. Street and Number		10f.	Zip Code	10	g. Citizen of What Cour	itry?	
th the 23a or notifie		29853 Skipton		Road	21625		USA		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married 1	2. Was Decedent Ever in U Armed Forces?		edent of Hispanic Origin? (ecify Cuban, Mexican, Pue		14. Race - Americ White, etc.	can Indian, Black,	
after ral", o	by F	3 Widowed 4 Divorced If)	es, Give Year Dates:	1 Yes	2 No specify:		Specify: B10	ick	
hours after "natural",		15. Decedent's Education (Specify only harmonic Elementary/Secondary (0-12)	College (1-4 or 5+)		ual Occupation (Give kind working life. DO NOT use		16b. Kind of Business/li	ndustry	
nore, MD 21215-0036 gas I and 2 should be filed within 72 nt of Health and Mental Hygiene. t: If item 27 is marked other than ' other traumatic event, the Methen	Completed	Lienterially/secondary (0-12)	College (1-4 of 5+)	unev	ployed		None		
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ore, MI es 1 and 2 s of Health a If item 27 her traum		20a. Method of Disposition	20b. I	Place of Disposition (Name of cemetery,	Date Date	20c. Location - City of	Town, State	
등 등 등 등 등		1 Burial 2 Cremation 3 Donation 5 Other Specify:	INCHIOVAL HOLLI STATE A	,	enetery 9	7/12/10	Ridgely N	laryland	
Baltimore, MD 21215-00: permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other i injury or other traumatic event, the Ma		21. Signature of Funeral Service Licensee	262		and Address of Faility ry funeral washingto		4-		
Physician	-	23a. Part / Enter the disease, or complicat	ions that caused the death	. Do not enter the mo	<i>Lusa Shi ng to i</i> de of dying, such as cardia	ic or respiratory arres	abridge, Ni st, shock, or Heart	Approximate Interval	
/Medical		failure. List only one cause on each I Immediate Cause (Final disease a. Sta	ine. ab Wound of Chest					Between Onset and Death	
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	to (or as a consequence of	f):					
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3760, ficate be executed g physician and s the burial - transi	n/Medical		MENDED	_					
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Vital Revision: The his certificate director, page	Be	25. Was case referred to medical examiner? [Hosp	ital:		26 Place of Death (Chec				
of Vi	리	1 ✓ Yes 2 No 27. Manner of Death	1 Inpatient 2 ✓ 28a. Date of Injury	ER/Outpatient 3	DOA Other: Nur 28c. Injury at Work?	sing Home 5 R	esidence 6 Other:		
Division of Vital Records, rat or Attending Physician: The law requir rs after death. al Director: After this certificate has been sted in by the funeral director, page 2 should be	흲	1 Natural 5 Pending	(Month, Day, Year) Sep 3, 2010	0000 hrs	1 Yes 2 ✓ No	Subject stable			
Division pital or Attent ours after death eral Director: filled in by the	ifica	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome, farm, street, fact	ory, office building, etc.		reet and Number or Run	al Route Number, City	
Di lospital f hours a uneral I	Certification:	4 V Homicide determined	(Specify) Single Fam	nily Home		or Town, Sta 29853 Skipton-	ote) Cordova Road, Cord	dova, MD	
the H iin 24 the F	Medical	one) 2 Medical Examiner: On	To the best of my knowledg the basis of examination ar						
To To Com	Med	29b. Signature and title of certifier	I manner stated.	-	29c. License number		29d. Date signed (Mon	th, Day, Year)	
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		and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s	pleted cause of death (Item		Stroot Baltiman	MD 24204			
St	ate		sistant Medical Exam		n Street, Baltimore, I	IVID 21201	<u></u>		
Regist	rar	31. Date filed (Month SEP 9 201	y Denous	in fan					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Billy C. Hamilton 2:50 P M /Medical September r 4, 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Ye, July 11, 9. Birthplace (State or Foreign **Funeral** Year) 1944 1**⊠** M 2□ F Months Days Hours Min. 450-70-0344 66 Texas Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show of other than "natural", or items 23a or 28a-f sho event, the Medical Evaminer must be notified at 1 ☐ Yes 2 No Director MD Charles Waldorf 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3609 Pine Cone Circle 20602 USA Funeral 12. Was Decedent Ever in U.S.
Atmed Forces?
1 ∑Yes 2 □ No
If Yes, Give
Year or Dates: 1979-94 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or ite any Injury or other traumatic event, It a Medical Examina 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: Black Specify: \$ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Postage Handler U.S. Post Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie L. Hamilton Bertha Stern ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Billy C. Hamilton, Son 21022 Lemon Springs Terr. Ashburn, VA 20147 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State 20a. Method of Disposition 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran's 4 □ Donation 5 □ Other (Specify) 9/13/2010 Cheltenham, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 71.0 Everly-Wheatley, 1500 W. Braddock Rd Alexandria VA Khu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a nonsequence off cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) P.O. signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ Sepsis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No Angemia 24a. Was an has Thrombocy topenia certificate 1 ☐ Yes 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 🔽 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) eyan.c. D 50653 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURANA 5851churchton Deale Road. Deale 20757

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) SEP 1 5 2010

32. Registrar's Signature

		For State Registrar	riode	State o	f Marylar		artmen tificate			nd M	ental Hy	gien Reg. N	7111)	30528
Physicia Medic		1. Decedent's Name (Fi		ŕ							2. Date of De Month		^{ay} 2010 ^{Yea}		3. Time of Death 5:50 p
Examin		4a. Facility Name (if not institution, give street and number) 1511 Market Street				Pocc	moke	ocation of	7		4	c. County of De Worcest			
Funeral Director		5. Social Security Numb 215-50-5270 Usual Residence of Dec	0	. Sex 1 Ж M 2 □ F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bi		g. E Was	Sirthplac Country)	e (State or Foreign
Aaryland Ba-f show tified at	rector	10a. State 10	orcest	er	1	ty, Town or Loc		,						10d.	Inside City Limits 1X Yes 2 No
with the Pis 23a or 2	Funeral Director	10e. Street and Numbe		et			10f. Zip	^{Code} 2185	1			10g. C	itizen of What (?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 3 Widowed 4	_	Armed Fo	2 ⅓ No e	- 1	Vas Deced Yes, spec			in? (Spec Puerto F	eify Yes or No- Rican, etc.)		14. Race - An Black, Wh Specify: Wh	nite, etc.	Indian,
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id 2 should ealth and M n 27 is ma er traumal		19a. Informant's Name. Kathleen He					_					-	or Town, State, MD 2185		е)
. Page 1 ar ment of He tant: If iter jury or oth		20a. Method of Disposi 1 Deurial 2 XC 4 Donation 5	Oremation 3		State _	Place of Disponentery, creming C	rematory or or	her place Ly	9	/14/		Sal:	ocation - City	Mar	yland
permit Depart Impor any in		21. Signature of Funera		140	Qum								sional As MD 218	soci. 51	ation
Physician/ Medical Examiner	Examiner	23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)													
ath certificate be executed attending physician and for use as the burial-transit	ical	that initiated events resulting in death) Last		cDue to (or as a conseq	uence of):									
e death certifi the attending thed for use a	Physician/Med	IF FEMALE: 23b. Was decedent prepared in the past 12 mon 1 Yes 2 N 9 Unknown	ths?	1 🔲 Live	Birth 2 Teta nant at time of	ne of pregnancy h 2							23d. Date of delivery Month Day Year		
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sician: The law rec s certificate has bee lirector, page 2 sho	Completed by										24a. Was auto perfo 1 \(\sum \text{Yes}\)	psy ormed2	prior to death?	o compl	findings available etion of cause of
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To the Hospital or Attern Within 24 hours after dect To the Funeral Director completed filled in by the	al Certificate:		Could no determine	t be 28e. Place	of Injury - At ho		et, factory			_	8f. Location (City or To		nd Number or F	Rural Ro	ute Number,
o the Hosp rithin 24 hou o the Fune ompleted fi	Medical	(Check 2 \square	Medical Exa Certifying N	hysician: To the be aminer: On the bas urse Practioner:	s of examinatio	n and/or invest	igation, in r eath occur	ny opinion	, death occ time, date a	urred at t	he time, date	and plac ne cause	e, and due to th	e cause(as stated	
F 5 F 0		30. Name and address	7	o completed caus	e of death (Item	n 23a) (Type, P	C	000	619	8		9	14/10	,91	
라 10 Stat		Justinian 31. Date filed (Month, Da	Ngaiz	a, MD -		Carrol dure	L St.	, Sa	Lisbu	ry,	MD 218	01			
 Registra 	ar	30	LIO	LUIU /A	was.	C. Da	wed								

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 30529 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 4:27 pm Alden Lane Howard September Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Casey House 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 02/03/192 1 X M 2 🗆 F Days Hours Director 577-40-9719 84 .ouisiana Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Adelphi 1 Yes 2 X No Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10404 Tullumore Drive 20783 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give 3 Divorced WWII White. Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Custom Picture Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Frame Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alden Lane Howard, Sr. Nolia Bouvier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |Margaret S. Howard - Spouse 10404 Tullymore Drive, Adelphi, Maryland 20783 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Lincoln Crematory 09/14/2010 | Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. ne Marie 11800 New Hampshire Ave.. Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Debility disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypoxic Respiratory Failure Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or linjury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlar-transit Chronic Obstructive Pulmonary Disease that initiated events Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Acute Renal Failure 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed^a Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗓 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSpice 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural 5 Pending 1 Tes 2 No Investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 115108 10+1 September 12. 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Diane Ruckert.

31. Date filed (Month, Day, Year)

CRNP,

32 Registrar's Signature

6001 Muncaster Mill Road, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30530 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year Eileen Catherine Hatfield P^{M} Sept. 2010 6 7:40 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Brighton Gardens N. Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 🖳 F Months Days Hours Min 364-01-1399 Mar. 4, 1918 Michigan Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location MD 1 ☐ Yes 2 No Montgomery N. Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5550 Tuckerman Ln. #334 20852 United States 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: 3₺ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas A Kalahar Mary Carey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Hatfield/Daughter P.O. Box 80043 Charleston, SC 29416 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 9/16/2010 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Ft. Lincoln Crematory 8/16/2010 Brentwood, Marvland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease shock, or eart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cahe (Final disease or condition resulting in death) Failure to Thrive Due to (or as a consequence of) Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Atherosclerotic Heart Disease Due to (or as a consequence of):

Physician /Medical Examiner $\mathcal{H}atticld$, $\mathcal{E}/\mathcal{L}_{\mathcal{U}}$ Division of Vital Récords, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be (

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modeal France.

Examine Hospital or Attending Physician: The law requires that the death certificate be emcuted At hours after death.

Eurneral Director: After this certificate has been signed by the attending physician and eating filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical director, page 2 should be det ģ Be Completed Medical Certification: To To the Hosp within 24 hor To the Fune completely fi

	d									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23d. Date of d Month	elivery Day	Year							
Part II. Other significant conditions of	contributing to death but not res	ulting in the underlyin	g caus	se given in Part I.		23e. Did tobacco u 1 ☐ Yes 2 [e of death?	
						24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No	prior to death?	completion	ings available of cause of	
25. Was case referred to medical examiner?	26. Place of Death (Check only one)									
1 Yes 2 Mo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence							ecify)		
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		Injury at Work? 1 □ Yes 2 □ No		28d. Describe how injury occurred				
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Special	Location (Street and City or Town, State)	eet and Number or Rural Route Number, State)							
29a. Certifier (Check only one) 1 Certifying R 2 Medical Example 1	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurration and/or investigati	ed at t	the time, date and plac my opinion, death occ	e, and	d due to the cause(s) at the time, date and	and manner a place, and du	as stated. e to the cau	ıse(s)	
29b. Signature and title of certifier	5-11-011	2	29c. Li	cense number		29d. Date	e signed (Mon	th. Dav. Yea	ar)	

D53691

Rockville, MD 20850

September 10, 2010

State Registrar

e Funeral I

#110,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tower Oakes Blvd,

. Registrar's Signature

Ajay Reddy 3200

31. Date filed (Month; Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 3053 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPT. 2016 MICHAEL HORTON W. SR. 2:15 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Min. APR. 28, Months Hours Year 1949 Director 61 Yrs MARYLAND 214-52-0301 TDD: 03:15 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important If liem 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DELAWARE SUSSEX SELBYVILLE 1 X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 CEMETERY ROAD 19975 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian rmed Forces DOD: 9/13/10 Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 2 No If Yes, Give Year or Dates.1968–69 1 ☐ Yes 2 X No Specify 3 Divorced Completed Specify WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) WATERMAN SEAFOOD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ WOODROW HORTON **EDWARD** LOTTIE 208:4/28/49 MAE THORNTON permit. Page 1 and 2 shoul Department of Health and Important: If item 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA A. HORTON/WIFE CEMETERY ROAD, SELBYVILLE, DELAWARE 19975 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) CREMATORY OF DELMARVA 9/17/10 DELMAR, DELAWARE 21. Signary re of Fu 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enysician/ Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or impury that initiated experts.) Examine Due to (or as a consequence of) the burial-tran that initiated events resulting in death) Last 24-52-030 Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 phy for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year s been signed by the s 1 L Yes 21. 9 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an , page 2 To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h Dependent of the Puneral Director, After the Spagneted filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Certificate: To 1 🗌 Yes 2 📉 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 Tes Investigation 2 🗌 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined

Registrar DHMH 17 Rev 7/2009

State

Medical

29a. Certifie (Check

only one 29b. Signatura

30. Name and address of per

SEP 1

1

and title of certifie

amond MD

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D56307

who completed cause of death (Item 23a) (Type, Print)

CMD, Atlantic General Hospital, 9733 Healthnay Drne, Berlin, MD 21811

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

City or Town, State)

September 13,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 30532 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month Pearl B. Hoffman 7:12 M Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CONSTAL HOSPICE AT THE LAKE WiC 15 oMico If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 8. Date of Birth (Month, Pay Year 2 - 1 - 1 2 2 4 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign MD Country) 1 □ M 2 💢 F Director 215-12-6100 86 Usual Residence of Decedent 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f si any injury or other traumatic event, the Medical Examiner must be notified. 1 XYes 2 No MDWicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 518 Priscilla Street 21804 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Ď ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Henry A. Bonnett Nora Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Ardis/Daughter 518 Priscilla Street, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9-14-2010 Dover, DE Crematory, 21. Ingnatur of Funeral Service Lic 917 W. Isabella St. Salisbury, MD 21801 Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final ey Ocelegion in Filtysician/ Onset and Death crebiel disease or condition 1220 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ extens Completed 1 ☐ Yes 2 🕏 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 X No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 2 🗆 Accident 5 Pending injury work? Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number D29505 09-11-2010 M. Bellex ecoporus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO M.D. 5302 (HINABERRY DR., SALISBURY, MD 21801 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 4 2010 Registrar

1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene 30533 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month STEFAN MICHAEL JOYNER P^{M} SEPTEMBER 2010 6:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 XM 2 - F AUGUST 31 Vrs **Director** 52 1958 071-52-1577 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f MARYLAND HARFORD 1 ¥ Yes 2 □ No ABERDEEN 10e Street and Number 10f. Zip Code ms 23a or must be n 10g, Citizen of What Country? Funeral 601 CORNELL STREET 21001 UNITED STATES items 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 □ No If Yes, Give Year or Dates 1977 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner ò þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", 3 - Widowed 4 X Divorced Specify: BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) LABORER BOTTLING (BEVERAGES) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ LEON LEE SAUNDRA CROMWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. THURL B. SNELL / AUNT 554 ALLIANCE STREET, HAVRE DE GRACE, MD 21078 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FERRIS & CO, INC 9/20/10 WEST CHESTER. PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A.
552 LEWIS STREET, HAVRE DE GRACE, Scott - Coleman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Tromasorisa Physician/ DISSEMINATED disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence on). Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the Hospital or Attending Physician: The law requires that the P.O. Joyner, Stefan Michael signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ûnknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy perform death? Yes Division of Vital 25. Was case referred to medical completed filled in by the funeral director, å 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Tyes 1 Minpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After Natural 5 Pending 1 Tes Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signat and title of certific 10029546 -2010 30. Name and address of personnyho completed cause of death (Item 23a) (Type, Print)

JASON Birnbaum 500 Upper Chesapeake Drive Belair, Md 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

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2	¤ £ 2, ₹		Cynthia Hedgepet	h - Daughter								MD 20744
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	I to the hospital or Attending Prysician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (rsician: To the best of my kno iner: On the basis of examina and manner stated.								
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2	KI [30. Name and address of person who c				4 T	4 TT1	dmater	MT	207//	
	Sta	ite	Arvind Narasimhan, 31. Date filed (Month, Day, Year)	MD 11711 Li 32. Registrar's Signa	ture	on K	u. r	ı. wasn	THR COL	MD	20744	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30535 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Sylvester Roosevelt Jones 09-07-2010 11:33aM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 579-50-3635 1 □ xM 2 □ F Days 71 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Capitol Heights Prince George' 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1226 Benning Road #208 20746 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 XWidowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Gov't Statistician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Woodie Jones Rosia Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renee Jones-daughter 4252 Suitland Rd. Suitland MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Riverdale Crem. 09-10-2010 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility 20746 Cedar Hill FH,4111 PA,Ave.,Suitland, MD

Physician/ Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ttending physician and or use as the burial-transit

ed by the detached

certificate has

within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, i

To the Hospital within 24 hours a To the Funeral C

Physician/

Medical

Director

Funeral

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Completed

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10a. State

MD

Examiner

Funeral

Director

or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me

Examine Medical Certificate: To Be Completed by Physician/Medical

	shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line. metastatic]		r respiratory arrest,		Approximate Interval Between Onset and Death			
	resulting in death)	Due to (or as a consequence of):							
	Sequentially list conditions, if any, loading to himmediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as a consequence of):							
	that initiated events resulting in death) Last	C. Due to (or as a consequence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown		Ectopic pregnancy Other (specify)		23d. Date of de Month	olivery Day Year			
	Part II. Other significant conditions co	ontributing to death but not resulting in the unc	derlying cause given in Part I.			the cause of death?			
				24a. Was an autopsy performed 1 Yes 2 4	prior to death?	ntopsy findings available completion of cause of			
1	25. Was case referred to medical examiner?		26. Place of Death (Check	only one)					
ı	T LI TES 2 LAFINO	Hospital: 1 X Inpatient 2 - ER/Outpatient	3 ☐ DOA Other: 4 ☐ Nursing Hor	ne 5 🗆 Residence	e 6 🗆 Other (Spec	cify)			
	27. Manner of Death 1 A Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year) 28b. Time of injury		28d. Describe how injury occurred					
	4 Homicide determined	28e. Place of Injury - At home, farm, street building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	only one) 3 Certifying Nurse	ician: To the best of my knowledge, death occ ner: On the basis of examination and/or investiga e Practioner: To the best of my knowledge, dea	ation, in my opinion, death occurred at t	the time date and no	ace and due to the	cause(s) and manner stated			
4	29b. Signature and title of certifies		29c. License number	294	Date signed (Month	Day Vear			

D0061887

09-07-2010

State

Registrar

Ira Rabin, MD 1500 Forest Glen Rd., Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

SEP 1

3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ r 10, Year 2010 0 September 11:42p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgomery Olney 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 76 Yrs. 8. Date of Birth
(Month, Day, Year)
Nov. 1, 1933 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 253-54-0762 1 □ M 2 😿 F Months Hours Georgia **Director** Usual Residence of Decedent 28a-f shov 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring M D Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral United States 20904 812 Hobbs Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White, etc. African Specify: American þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Battimore, Maryland 21215
permit. Page 1 and 2 should be filed within 72 I
Department of Health and Mental Hygiene,
Important if item 27 is marked other than "n
any injury or other traumatic event, the Medi Elementary/Seconday (0-12) College (1-4 or 5+) Education Educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Julia Gaskins Alexander Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheryl C. Oliver -daughter Hobbs Drive, Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖺 Burial 2 🗌 Cremation 3 🗀 Removal from State Arlington Nat'l Cem. 10/15/2010 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) McGuire Funeral Service, Inc. Signature of Funeral Service Licenses 22. Name and Address of Facility 7400 Georgia Avenue, NW, Washington DC 20012 Hey 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Ph sician/ neum disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nin 24 hours after death.

the Funeral Director: After this certificate I mpleted filled in by the funeral director, pag 1 Yes 2 No 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred **□** Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year) Loure mo 6067294 010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ata Motamedi, M.D.; 17904 Georgia Avenue, Olney, MD 20832

State Registrar 31. Date filed (Month, Day, Year)

82. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 30537 State Registra Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year 2:56 PM Kirk 19.20p Henry Harold otember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Lions Center** Allegany Cumberland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours Min. 1 □ M 2 □ F 232-24-4994 Director 88 Apr 6, W.Va 1922 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits r than "natural", or items 23a or 28a-f shor the Modical Examiner must be notified at WV Mineral Wiley Ford Director 1 □Yes 2 □No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rt. 1 Box 38 26767 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ No If Yes, Give Year or Dates: Specify: þ Specify: 1943 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mertal Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, I'm College (1-4or 5+) Manager Tire Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence Kirk Effie (Turner) Kirk ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Kirk Wife Rt. 1 Box 38 Wiley Ford WV 26767 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗷 Burial 2 Cremation 3 🗆 Removal from State Rocky Gap Veterans Cemetery 9/25/2010 4 ☐ Donation 5 ☐ Other (Specify) Flintstone MD 22. Name and Address of Eacility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Partf. Enter the disease, or complications that cau of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atherosclero trc androvascular disease or condition resulting in death) 6months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy igned by the atte be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforr 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Certification: To 1 ☐ Yes 2 X No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No 24 hours after deat Funeral Director: ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only within 2. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bishop Walsh Rd, Cumberland, MD21502 31. Date filed (Month, Day, State

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 September 11:00 AM Joseph Kulaga Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ceci1 Union Hospital of Cecil County E1kton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Nov. 18 9. Birthplace (State or Foreign Country Newark New Jersey 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🗆 F Days Hours Min. Months Director Yrs 1915 136-05-4620 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 x Yes 2 ☐ No Florida Broward Plantation 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1100 S.W. 69th Avenue 33317-4245 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Was Decedent Even in J.S.
Armed Forces?

1 Xyes 2 No
If Yes, Give
Year or Dates. US Army Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 XDivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Cement Company Truck Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Kulaga Mary Urbanski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Kulaga / Son 301 Maloney Road, Elkton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) September Mayerdale Crematory Newark, Delaware 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ACU TE Physician, RENAL Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, teaching to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner INFARCT attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 2 N 1 Yes 2 No Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) eral Director: After this filled in by the funeral di 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours a within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29d, Date signed (Month, Day, Year) MI> D 63486 SEPTEMBER, 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOW STREET 12+1VA HAMADEH 106 , ELLISON, MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 30539 State Registra Amend#23a. PerPhys. PGC9-16-10 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Vivian F. Kelley September 8, 0:124 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Yea OV 21, 19 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Days Hours Min. 59 579-68-7751 Director Yrs 1950 Washington, Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director r than "natural", or items 23a or 28a-f s the Medical Examiner must be notified Maryland Prince George's Upper Marlboro 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>11413 Honeysuckle Court</u> 20774 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. **African** Armed Forces þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: American Completed 3 № Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Should be filed within 72 h and Mental Hygiene.
7 is marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) Government OPM Manager traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Nathaniel Ferguson Thelma Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sof Health 1409 3rd Street Glenarden, MD 20706 Thomas M. Ferguson - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 A Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery Sept 15, 2010 Brentwood, MD 4 Donation 5 Other (Specify) ature of Funera ervice ice 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part & pyter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Septic Shock Pneumonia Medical resulting in death) Due to (or as a consequence of) Examiner Pulmonary edema Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No ò Month Day Year the page 2 should be detached 9 🗌 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? certificate Yes 2X No s after death.

I Director: After this certific d in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 2 🔀 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 🛣 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed 2 Medical Examiner: Of the basis of examination and on investigation, many opinion, detailed and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sargethe R MD D69835 8 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sangeeta Ranganath, M.D. 1500 Forest Glen Road Silver Spring, MD 20701 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

SEP 1 6 2010

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	1	For State Registrar		se Type or Pri State of M		d / De	oartment of ertificate of	Hea	alth a				20	10	305	540
ysician/ Medical	Ī	1. Decedent's Name	, , , , , , , , , , , , , , , , , , , ,	ast)							Date of D Month	eath Da	ay	Year	3. Time of	Death
Examiner	4	a. Facility Name (if	haa	ive street and number)	Hoso	. +a	4b. City, Town		tion of		,	40	c. County	of Death	bot	
eral ctor	5	. Social Security No.	umber 6		e (In yrs. Va	st <i>birthd</i> ay Yrs.) If Under 1 Year Months Day	ar If	Under 2	4 Hrs. 8.	Date of B	irth av, Year)	943	9. Birti Col NE	nplace (State or intry) YORK	r Foreign
ad at	-	Jsual Residence of Oa. State	Decedent 10b. County		10c. City	, Town or	ocation								10d. Inside Cit	ty Limits
rem 27 is marked other than "natural", or rems 22a or 26a-1 show other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director		1ARYLAND Oe. Street and Nur	TALBO mber	OT		TRA	10f. Zip Code)				10g. C	itizen of \	What Co		NO LAS
Funeral			OSLYN F	ARM ROAD	F '- 110	- 14		2167		n2 (Specific	Von or No	_			TATES	
ed by Fu		 Marital Status Never Marr Widowed 	ried 2 Marrie	d 12. Was Decedent Armed Forces? 1 ☐ Yes 2 【 If Yes, Give Year or Dates.			. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 2 1			Puerto Rica	an, etc.)	, <u> </u>	Blac	e - Amer k, White		
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uny or			Cremation 3 5 Other (Spe	Removal from State	CHES	APEA CEN	KE CREMAT CER	TON	S	EPT. 2010	12	STE	VENS	/ILL	E, MARY	LAND
any injury or other once.		21. Signature of Fu	neral Service Lic	ensee		Į,	22. Name and Add FELLOWS, 106 SHAM	HE ROC	f Facility LFEN K RO	BEIN	& NE	WNAM	FUNI	ERAL	HOME P 21619	.A.
cian/		23a. Part 1. Enter t shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List onl (Final	omplications that caused y one cause on each line a.	e. Nor	niscl		ying, su	uch as c	ardiac or re	spiratory				Approximate Interval Bette Onset and D	ween
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70		that initiated events resulting in death) i	S	Due to (or as	a consequ	ence of):	yperte			~	J					
Physician/Medio	1 2	F FEMALE: 23b. Was decedent in the past 12 I 1 Yes 2 5	menths?	23c. If yes, outcome 1	2 🗌 Fetal	death 3	☐ Ectopic pregna ☐ Other (specify)							te of del	-	/ear
l by Pi	۱'	Part II. Other signif	ficant conditions	s contributing to death t	out not resu	ulting in th	underlying cause	given i	in Part I.						the cause of decorably 4	
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pleted filled		(Check 2	Medical Exa	hysician: To the best of aminer: On the basis of e lurse Practioner: To the	examination	and/or inv	estigation, in my op	inion, d	death occ	curred at the	time, date	and plac	e, and du	e to the c	:ause(s) and ma	nner stated
		29b. Signature and	title of certifier	~ M	7		29c. Lice			567		29d. D	ate signe	1	n, Day, Year)	
State			ess of person wh	o completed cause of completed by SOUTH WAS	leath (Item	ON S	, Print)				AND 2	21601	1 1			

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			For State	Amend 24a State of Ma	per arylan					Mental H	ygiene	Legible.	
			Registrar			Cer	tificate	e of De	eath		Reg. No.	2010	3051.1
	Physicia Medi		1. Decedent's Name (First, Middle, La Donald E. K	ahler						2. Date of D Month		$3-20^{\text{Year}}$	3. Time of Death 11:22 p M
4	Exami	ner	4a. Facility Name (If not institution, given Joseph Rich	,	се			Town, or La 11tim	ocation of Deat Ore	h	4c. (County of Death	
	Funeral Director		303 10 4430	Sex 7. Age	92	ast birthday) Yrs.	If Under Months		f Under 24 Hrs Hours Min.		irth 3, <u>Y</u> 9279 1	9. Birth Cour	place (State or Foreign
	and show	١	Usual Residence of Decedent 10a. State 10b. County		10c City	y, Town or Lo	cation						10d Ippida City Limita
	Marylar 28a-f sh otified	irecto	DC			hingt							10d. Inside City Limits 1 X Yes 2 No
	72 hours after death with the Maryland n"natural", or items 23a or 28a-f sho fledical Examiner must be notified at	Funeral Director	10e. Street and Number 3834 Carpen	terStreet	t		10f. Zip	Code 0020			10g. Citiz US	en of What Cou	ntry?
	r death or items iner m	y Fun	11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 🔯 Yes 2 🗆	ver in U.S		Vas Deced f Yes, spec	lent of Hisp cify Cuban,	anic Origin? (S Mexican, Puert	pecify Yes or No to Rican, etc.))- 1	4. Race - Americ Black, White,	
900	urs afte tural", c	Completed by	3 → Widowed 4 □ Divorced	If Yes, Give Year or Dates.	No 1945	-46	∏ Yes 2	2 🖂 🗸 Io	Specify:		s	_{Specify:} Whi	
215-	n 72 ho	mple	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12)	ducation ade completed) College (1-4 or 5		16a. Deced (Give I life. Do		k done dur	on ing most of wo	rking		d of Business In	
213	d withii ygiene her th	ပို		1-4	+)	Budg	et A	naly	st		F €	ederal	Gov't
Marvland 21215-0036	ld be filec Mental H larked ot atic even	To Be	17. Father's Name (First, Middle, Last) William C.	Kahler						me (First, Middle Rohd		urname)	
	nd 2 shou sath and n 27 is m er traum		19a. Informant's Name/Relationship (7) Gary R. Kahler	· · · · · · · · · · · · · · · · · · ·								own, State, Zip (
$\%\sim$ Baltimore.	permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	20b. P	lace of Disposemetery, cremetery	sition (Nam natory or ot lill	ne of ther place) Ceme	tery9	Date / 13 / 20	20c. Loc 10 Si	ation - City or To	own, State
2/2 Balti	permit. Departn Imports any inju		21. Signal of Funeral Service Licent	see	^			d Address	-	4111 P.	A , A v e	e.,Suit	20746 land,MD
1		(23a. Par 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final	plications that caused ne cause on each line.	the death								Approximate Interval Between
-	Physician/ Medical	8 8	disease or condition resulting in death)	a. <u>metas ta</u> Due to (or as a	ti c	ence of):	mya	sarca	oma o	f abdi	mer	1	Onset and Death
0	Examiner	Jer	Sequentially list conditions,	b.	Co. H. Comp. AC.	era e sili							
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876	tificate ng phy as th	Med	IF FEMALE:										
d Kahles 8876	To the Hospital or Attending Physician: The law requires that the death certificate t within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the total states.	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	? 🗌 Fetal	death 3 _	Ectopic p Other (spe	regnancy ec <i>ify)</i>			23	3d. Date of deliv Month	ery Day Year
ੁਟੂ ਰ •ੁਟੂ	es that the des signed by the a i be detached i	by Ph	Part II. Other significant conditions of		t not resu	ulting in the ur	nderlying c	ause given	in Part I.	23e. Did	tobacco use	e contribute to the	ne cause of death?
$\stackrel{\sim}{\prec}_{s}$	require been sign	leted	bactermia, E.C.	01,							Yes 2	<u> </u>	bably 4 Unknown
Reco	s ician: The law is certificate has the lirector, page 2 s	Completed by										prior to co death?	mpletion of cause of
व्य	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:				L OUIL	of Death (Ched				1
of Z	g Phys er this eral di	e: To	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 Inpatie	, :	ER/Outpatient 28b. Time of		Bc. Injury at	4 🗌 Nursing H	ome 5 Res			hospice
A IS	ttending death. tor: After	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not b			injury	М	work?	2 □ No				
Division	ital or A		4 Homicide determined	28e. Place of Injur building, etc.	(Specify)					City or To	wn, State)	Number or Rural	
3	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical	(Check 2	sician: To the best of m ner: On the basis of exa e Practioner: To the b	mination	and/or investi-	gation, in m	ny opinion d	death occurred a	at the time date	and place a	nd due to the car	ise(s) and manner stated
# _	vithi 70 th		29b. Signature and title of certifier				29c.	License nu	mber			signed (Month, i	
)	-		Meneno				107			09/0	01/10	
CR	20		Camille Menino Ci	RNP, 828	N.	Euta	ws	i+.]	Balti	more	mD	21201	
	Stat Registra	е	SEP 1 4 2010	32. Registrar	s Signatu	W		Í					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William Licurgo 2010 р Beptember $4 \cdot 10$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Waldorf Charles <u>Genesis of Waldorf</u> Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) April 15, If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Min. Hours Director Yrs. 1935 Pennsylvania 194-26-8725 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2XX No Maryland Charles White Plains 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20695 3795 Tarrington Place 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 🗆 Widowed 4 🗆 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry alth and Mental Hygiene. 27 is marked other than r traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12th <u>Furniture</u> <u>Repair</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas Licurgo permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. Ruth English 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma Licurgo/ Wife <u>3795 Tarrington Place, White Plains, MD. 20695</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) <u>Trinity Mem.</u> <u>Gardens Sept</u> 16, 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licensee 1190 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres Approximate shock, or heart failure. List only one cause on each line Onset and Control Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi). that the death certificate be executed as the burial-transi Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No for Month Year Day page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 2 🗌 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to of Vital Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **N**0 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident
3 Suicide 5 Pending Division 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier f person who completed cause of death (Item 23a) (Type, Print) LINE (ENFA 12070 M,D

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State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Maryla		artment of H tificate of L		lental Hy	giene	
			Registrar	Reg. No. 2	30543					
	Physicia	an/	Decedent's Name (First, Middle, Last)					Date of Dea Month	ath Day Year	3. Time of Death
	Medi	cal	Anne R. Larkin					Sept.	13 2010	0 4:10 A M
	Examir	ıer	4a. Facility Name (if not institution, give s	reet and number)		4b. City, Town, o	Location of Death		4c. County of Dea	ath
and the same	F		Casey House 5. Social Security Number 6. Sex	7 Ago //n ym	last birthday)	Rockv:		0.001- (8)	Montgo	
	Funeral Director				76 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day	(, Year) C	rthplace (State or Foreign ountry)
	*		Usual Residence of Decedent					July 2	4, 19341 Mas	ssachusetts_
	/land f sho	ţ	10a. State 10b. County	10c. C	City, Town or Loc	cation				10d. Inside City Limits
	Man 28a- otifie	Director	MA Bristol	W	estport					1 ☐ Yes 21 No
	th the	<u>=</u>	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	th wit	Funeral	147 J Cadmans Nec			02790			United Stat	es
	r dea or ite iner		11. Marital Status 1 Never Married 2 Married	Was Decedent Ever in U Armed Forces?	I.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Am- Black, Whi	
980	s afte al", c Exam	d by	3 ₺ Widowed 4 □ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	1	☐ Yes 2 🖾 No	Specify:		0	
Ö	hour natur lical	Completed	15. Decedent's Edu	cation	16a. Deced	ent's Usual Occup	ation		16b. Kind of Business	ite
2	in 72 e. nan "	Ĕ	(Specify only highest grade Elementary/Seconday (0-12)	College (1-4 or 5+)	(Give k	ind of work done of NOT use retired)	luring most of workii	ng	Tob. Wild of Busilees	industry
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Z	uld by I Mer narke natic	-	Leonard F. Reming				Elizabe			
Baltimore, Maryland 21215-0036	sho h and 7 is r traun		19a. Informant's Name/Relationship (Type	•	19b. Mailin	g Address (Street a	and Number or Rura	l Route Number	; City or Town, State, Z	p Code)
e,	and Healt		Peter Larkin, Dur 20a. Method of Disposition				ve., Trum	1		
nor	age 1 ant of t; If ii		1 ☐ Burial 2 🔀 Cremation 3 ☐ R		Place of Dispos cemetery, crem	atory or other plac	e) !)ate	20c. Location - City of	·
툪	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		Linco	1n_Crema			Brentwood,	Maryland
Ba	Dep Imp any onc		A A A A) H01403		Name and Addres		mple Tr	ibute ille, MD 2	0050
			23a. Part 1. Eny the dive se, or complic	ations that caused the dea						U632 Approximate
23a. Part 1. En the divense, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only one cause on each line. Immediate Crue & (Final disease or crue) in the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the caus										
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	e exec ian a irial-t	E E	resulting in death) Last	Due to (or as a conseq	juence of):					
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Division of Vital Records, P.O. Box 68760	ertifica ding p	Me	IF FEMALE:	If we automore of any						
×	ath certific attending p for use as	Physician/M	in the past 12 months?	c. If yes, outcome of pregna 1 Live Birth 2 Fet	al death 3 🗌		/		23d. Date of de Month	, , , , , , , , , , , , , , , , , , ,
m ·	the g	ysic	1 ☐ Yes 2 ☒No 9 ☐ Unknown	4 ☐ Pregnant at time of g ☐ Unknown	death 5 □	Other (specify)			MONTH	Day Year
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Ś.	requires that the de been signed by the should be detached	d by	Cecal_Vol	vulus						robably 4 🗆 Unknown
0.0	v requ	Completed	Danilde	777				24a. Was a	n 24h Were au	topsy findings available
ec	sictan: The law certificate has t irector, page 2 s	mo	Decubitus	ulcer				autops perfori	med? prior to death?	completion of cause of
	an: I		25. Was case referred to medical			26 Pla	ce of Death (Check	1 Yes	2 X No. 1 ☐ Yes	2 🔀 No
X	iysici is cel direc	TOE	examiner? 1 ☐ Yes 2 🔀 No	spital: 1 lnpatient 2	ER/Outpatient	Otho			ence 6 😾 Other (Spec	Hospice
o i			27. Manner of Death 1 🖾 Natural 5 🗆 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury	at 2		w injury occurred	ny) 1
0	ending eath.	Certificate:	2 Accident Investigation	(Month, Bay, 18ar)	injury	M 1 □ Y	res 2□No			
SIN :	fter d lirect n by	je	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stree	et, factory, office	2	8f. Location (Str City or Town	reet and Number or Rui	ral Route Number,
ַ בֿ	ours a						1		,	
:	24 hc 24 hc Fun eted	Medical	(Check 2 \square Medical Examiner	an: To the best of my know On the basis of examination	n and/or investic	iation, in my opinior	 death occurred at t 	he time date an	and of auth bore each b	squee/e) and manner stated
#	vithin o the	— г	only one) 3 ☐ Certifying Nurse F 29b. Signature and titl of certifier	Practioner: To the best of m	y knowledge, de	ath occurred at the 29c. License	time, date and place	, and due to the	cause(s) and manner as	stated.
	10		1 000	MO					9d. Date signed (Month	, vay, rear)
	10	H	30. Name and address of person who com		1 23a) (Type Pri	D371	44		9-13-2010	
			G. Coleman 1355 Pi				1			
	State	_	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	9				
	Registra	r	SEP 1 5 2010	Denora B.	LO CIRRA	1				

10-07102 Niva Lanae Lark Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Niya Lanae Lark		1- For State Registrar	tate of Marylan		artment c ertificate d		nd Menta		Reg. No. 2(110 3051
Physicia Medical Exami		Decedent's Name (First, Midd			*>**			2. Date of De	eath Day Yea	3. Time of Death
Medical Exami	ner	NIYA 4a. Facility Name (if not institution	LANAE on, give street and number		LARK	4b. City, Town, o	or Location of	Septemb	ber 15, 2010 4c. County of	0842 hrs
		5755 Cedar Lane				Columbia			Howard	
Funeral Director		5. Social Security Number	1	Age (In yrs.	last birthday)	If Under 1 Ye Months Da		24Hrs. 8. Date of E	3irth(MM/DD/YYYY	9. Birthplace (State or Foreign VTRGINIA
Director		697-14-0388 Usual Residence of Decedent	1 M 2 K F		Yr		14		1 2010	Country RGINIA
v any		10a. State 10b. County		10c. City	, Town or Loca	ation		, ,	-	10d. Inside City Limits
Maryland 28a-f show any 1 at once.	ō		INGTON	AR	LINGTON					1 X Yes 2 No
e Mary or 28a-	irec	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	nat Country?
r death with the Maryland , or items 23s or 28s-f sho must be notified at once.	Funeral Director	2514 S. KENWOO	D STREET 12. Was Deced	lent Ever in U	15 13 W		2206	n? (Specify Yes or N	USA	- American Indian, Black,
death v	nue	NT	Armed Force					Puerto Rican, etc.)	White	
s after ral", o	ē		vorced If Yes, Give Year or Dates:		1	Yes 2 X N			Specify:	BLACK
15-0036 filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f she i, the Medical Examiner must be notified at once	ted	15. Decedent's Education (Spe Elementary/Secondary (0-12)				nt's Usual Occupa most of working life			16b. Kind of Bu	siness/Industry
1036 vithin 72 ene. er than	Completed	0		o, ,		NON	NE		NONE	
1215-003 Id be filed within fental Hygiene. Instreed other the event, the Medi		17. Father's Name (First, Middle			<u></u>		1	Name (First, Middle,		
12 Id be Aenta narke	To Be	WINSTON LAR 19a. Informant's Name/Relations			19b. Mailin	na Address (Stre	LAVER	RNE BRADS er or Rural Route Nu		n State Zin Code)
and sho	-	LAVERNE BRADS			2.0					RGINIA 22206
ore, M es l and 2 of Health If item 2 ther traum		20a. Method of Disposition 1 X Burial 2 Cremation	n 3 Removel from		Place of Dispos crematory or ot	sition (Name of ce ther place)	emetery,	Date	20c. Location -	City or Town, State
Baltimore, permit. Pages 1 as Department of He. Important: If ite		4 Donation 5 Other Si	pecify:			CION CEME		9/23/2010	CLINTO	ON, MARYLAND
Ball permit Depar Impo		21. Signature of Funer Service	Licensee			Name and Addres				NERAL HOME
Physician 23a. Part I. Enter the disease, or expolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh								<u>JVER, MARY</u> rrest, shock, or hea	art Approximate Interval	
/Medical Examiner		Immediate Cause (Final disease	a <u>Sudden U</u>			eath in	Infanc	cy(SUDI)		Between Onset and Death
		or condition resulting in death)	Due to (or as a co							
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	nsequence o	of):					
_ #	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	nsequence o	ரி:					
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50, te be ex sysician	ledical	UNPENDED				perME,G9	09,11/	23/2010,W		
5876 srtificat ding ph	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	I Live birti	1	2 Fe	etal death 3	Ectopic pr	regnancy	23d. Date of o Month	delivery Day Year
Box 6876(The death certificate the attending physical for use as the break of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of th	Physician/M		4 Pregnant 9 Unknown	at time of de	eath 5 Ot	ther (Specify)				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit		Part II. Other significant conditi			esulting in the ι	underlying cause	given in Part I	I. 23e. Did 1	tobacco use contrit	bute to the cause of death?
S, P.O. uires that the signed by d be detach	ed by							1Ye	es 2 No 3	Probably 4 Vnknown
Cords law requir	ompleted							24a. Was auto	ppsy pr	ere autopsy findings available rior to completion of cause of
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ing Physi	읽	1 Yes 2 No 27. Manner of Death	28a. Date of li	njury	28b. Time of Ir		ary at Work?		how injury occurre	Other:
ttendin death. ttor: A	atio	1 Natural 5 Pend 2 Accident Inves	ling Fnd. 09	y,Year) 15 - -2010	Fnd. 7:30) AM	Yes 2 X No	° Unknown	1	
Divisi al or Att s after de I Direct	ertification:	3 Suicide 6 X Could	d not be 28e. Place of	Injury - At ho	ome, farm, stree	et, factory, office b	ouilding, etc.			r or Rural Route Number, City wiet Hours, Apt.
Lospita 4 hours 7 unera	ㅇㅏ	29a. Certifier	rysician: To the best of		sidence		ato and place	1100_Co1	lumbia,MD	21045
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	100	(Check only	miner: On the basis of ex and manner state	xamination ar						
E % E 8	\$	29b. Signature and title of certifier	r	u.		29c. Licens	e number			d (Month, Day, Year)
	L	hy his,	WO			O.C.I	M.E.		September	16, 2010
2_	1	 Name and address of person Ling Li, MD Assistar 	who completed cause of nt Medical Examin		· -	et, Baltimore,	MD 21201			
Sta	_	31. Date filed (Month, Day Year)			facel				··	
Registr		CERN D ZIMI	I Market and a	C. 48						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 30545 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, Day 2010 ear sept. Henry William Malec 3, 2:54 P 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death W. MD Regional Medical Center Allegany Cumberland 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min. 1**X** M 2 □ F Dec 14 1915 New York 94 097-16-8523 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2K No MD Allegany Frostburg 10g. Citizen of What Country?
U. S. A. 10f. Zip Code 21532 100 Village Park Way 12. Was Decedent Ever in U.S. Armed Forces? 1x Yes 2 No 194 IfYes, Give Year or Dates: 194 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1942 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2x No Specify: Specify: 3X Widowed 4 □ Divorced 1946 White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical 4 Physician Opthamalogist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Malec Anna (Stepian) Malec 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark C. Malec Son 16700 Harwood Dr., Frostburg, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Restlawn Mem Park Sept 8 2010 LaVale, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Hafer Funeral Service, P.A. of 1302 National Hwy., LaVale, MD 23a. Partal Enter the disease, pr shock, or heart failure. List complications that caused the death. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Due to (or as a consequence of): disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (ones a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Vear 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 ☐ Yes 2****No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 ☑ No 2DER/Outpatient 3 □ DOA 1 ☐ Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760. P.O. Records. Division of Vital **Physician**

Examiner

Funeral

Director

28a-f show

r items 23a or 28a-f shov

permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, its involved Extri, included any in the involved Extri, included.

Physician

/Medical Examiner

physician and s the burial-trans

attending ph for use as the

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certificate

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Baltimore, Maryland 21215-0036

death with

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

/Medical

Hospital or Attending Physician: The law requires that the death certificate be executed director, this funeral After t t hours after death.

uneral Director: Aftely filled in by the fun 24 hours a within 2. the

> State Registrar

Hedlen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

SEPTEMBER 42010

Harjit Sidhu, MD, 925 Bishop Walsh Rd., Cumberland, MD 21502

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

6 Could not be determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPT.18 ^{Day} 2010 12:45PM NANCY LYNN McCONATY Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death SOUTHERN MD. HOSP.CENTER PRINCE GEORGES CLINTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 ☐ F Months Days Hours Min WASH. **Director** Yrs .D.C. 215-70-9746 Usual Residence of Decedent fshov 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD. PRINCE GEORGES 1 Yes 2 XNo UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9132 GOLDENROD LANE 20772 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify:WHITE Completed 3 - Widowed 4 - Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MD, INDEP. NEWSPAPER STAFF WRITER <u> 12th</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 OWEN PAUL BROMLEY MILDRED ANNA SEVILLE e 1 and 2 should b of Health and Mer if item 27 is mark r other traumatio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GARY M. McCONATY-SPOUSE 9132 GOLDENROD LN. UPPER MARLBORO, MD. 20772 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date 20c. Location - City or Town, State SACRED HEART CEM. 9-24-10 LA PLATA, MD. 21. Signature of Feneral Service Licensee 22. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ AnoxIC disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Dilate attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 🗌 No Yes 2 🔀 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 2 🔀 No 1 X Inpatient 2 DER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation
Could not be within 24 hours after dear To the Funeral Director completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The discretishing injusted in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number DOU 28035 Sept, 20, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KULIA. MD BASIRMOHMAD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) ...

32. Registrar's Signature

Box 68760 P.O. Records, or Attending Physician: of Vital Division nours after death.

neral Director: Af
filled in by the fur Hospital

Baltimore, Maryland 21215-0036

To the Hospital within 24 hours a To the Funeral Completed filled

29a. Certifier

Could not be

determined

Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) okeans D37142 Sept. 9, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Coleman, Md 1355 Piccard Drive, #100, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature

🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number,

State Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 30548 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sept. 9, 2010 Helen MOSKOWITZ 11:37 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Sunrise of Rockville Rockville Montgomery Social Security Number If Under Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Sountry New York 1 🗆 M 2 😾 Adranth, Day, Year)922 Director 066-14-5027 88 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 20878 United States 604 A Main Street items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ō 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Specify: white "natural", traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meagones. Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rose Singer Morris Shulman 19a. Informant's Name/Relationship (Type, Print)
Robin Schnapper, Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 A Main Street, Gaithersburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 D Other (Specify) 09/14/10 | Boynton Beach, Eternal Light Cemetery Torretrinskysskiebnew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ Alzheimer's Dementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): for use as the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) the a 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2X No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed Yes 2 1 ☐ Yes 2 ☐ No pleted filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: မ 1 🗌 Yes 2 🛶 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred iniury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier 1🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 10, 2010

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Mittal,

14

Shama 31. Date filed (Month, Day, Year) D 0061382

14816 Physicians Lane, Suite 152, Rockville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 3. Time of Death 9:40P. 2. Date of Death Physician/ **MICHAU** SEPTEMBER ay 11, 2010 ANN Medical 4a. Facility Name (if not institution, give street and number, City, Town, or Location of Death Examiner 4c. County of Death Prince George's Sacred Heart Home . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 M 2 X F March 3 New Jersev 155-36-2284 92 Director "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's College Park 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9718 48th Place 20740 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 XWidowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel M. Kiernan Matilda Farber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dan Michau -son 9718 48th Place College Park, Maryland 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or Arlington National Cem. 10/19/2010 Arlington, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License ²Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Alzheimer's disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. From Industry, Cause (Disease or iinjury ie attending physician and for use as the burial-tra-Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Dav Year 4 Pregnant 9 Unknown Pregnant at time of death us the runeral birector: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia; Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🕅 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or in which may opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Contributing Number Practicular: To this best of my known count of the hard stated and place, and state and place, and the hard stated are the hard stated and place. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 13, 2010 D43121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nurul Chowdhury, M.D. 15216 Dino Drive Burtonsville, Maryland 20866

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 30550 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 11, 2010 Physician/ 1057 P M Samue1 Μ. Meyers Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Suburban Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 ★ M 2 □ F Hours Min. 04^MIBPIY9^Y20 PA 90 Director 164-12-6657 Usual Residence of Decedent alth and Mental Hygiene.
atth and Mental Hygiene.
attria marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD Kensington Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20895 United States 3500 Kensington Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Research Sociologist US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Elsie Taylor Alexander Meyers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 14305 Park Manor Terrace Rockville MD 20853 Pam Gorin - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 09/13/2010 Judean Mem. Grdns Olney, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funera monto 3 Edware and Address of Family Price Tion Inc 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) <u>Acute Respiratory Failure</u> Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation 1 ☐ Yes 2x No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Acute Renal Failure autopsy performed? Yes 2 No Chronic Kidney Disease 2 🗌 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: ပ 1 🗌 Yes 2 XNo 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pendina Accident Investigation within 24 hours after death

To the Funeral Director: / 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and itle of certifier 29d. Date signed (Month, Day, Year) 0068405 10 12/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jesus David Guevara-Nieto MD 5801 Nicholson Lane #1716 Rockville MD 20852

State

Registrar

31. Date filed (Month; Day, Year)

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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within 24 hours after death. To the Funeral Director: After this certification of the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director director, the funeral director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director di	Σ	only one) 3 Cer	rtifying Nurse	Practioner: To	the best of my	knowledge, d	gation, in my opinior eath occurred at the	time, date and pla	ce, and due to the	e cause(s) a	nd manner as	stated.	r stated.
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		30. Name and address of p	erson who co	mnleted cause of	· · · · · · · · · · · · · · · · · · ·	23a) (Type Pi	D006	4100		Septe	mber 1	3, 2010	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30552 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:32 PM Physician/ 2010 James Howard Martin, Jr. September Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital of Cecil County E1kton Cecil Social Security Number Sex 1XXM 2 □ F 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, June 3, Birthplace (State or Foreign Country) **Funeral** Director 215-58-0892 59 Pen<u>nsylvania</u> Usual Residence of Decedent 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2762 Old Elk Neck Road 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 iit. Page 1 and 2 should be filed within 72 hours amartment of Health and Mental Hygiene.

sortant: If item 27 is marked other than "natural" in the Medical Expensive sortant: If item 27 is marked other than "natural" in the Medical Expensive sortant. 1 ☐ Yes 2XX No Specify: If Yes, Give White "natural", 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Truck Driver</u> Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James H. Martin, Sr. Important: If item 27 is marke any injury or other traumatic Violet Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce A. Martin / Spouse 2762 Old Elk Neck Road, Elkton, Maryland 21921 20a, Method of Disposition 20b. Place of Disposition (Name of CilCentery, granatory or other place) Memorial Park Date permit. Page 1 Department of I XXurial 2 Cremation 3 Removal from State September Donation 5 DOther (Specify) Elkton, Maryland Signatu Funera service ensee 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** word ice Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 5 Other (specify) detached g Unknown 9 Unknown our runeral unrector. After this certificate has been signed by a completed filled in by the funeral director, page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending s after death Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/10 0062547

State Registrar 106 Bow

32. Registrar's Signature

alleps

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BMEUER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 30553 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James Musgrove, Sr. Month 6:00AM M 9 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Southern Maryland Hospital Center Clinton Prince George Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 577-64-7236 Months Days Hours Min. Aug 5 62 1948 WAShington, DC **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant; If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Prince George Accokeek 1 ☐ Yes 2 🌡 No 10f. Zip Code 10g. Citizen of What Country? Funeral 15901 Indian Head Highway 20607 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates Specify: 3 Widowed 4 X Divorced other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Musician Entertainment Be Father's Name (First, Middle, Last)
Om H. Musgrove, 18. Mother's Name (First, Middle, Maiden Surname)
Dorothy Hall ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James W. Musgrove, Jr./Son 15901 Indian Head Highway, Accokeek, MD 20607 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important; If it any injury or o cemetery, crematory or other place, Kalas Crematory 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 9/10/2010 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, MD 20745 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death
Unknown Dav Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🔀 Yes 2 🗌 No 3 🗌 Probably 4 🗀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? his certificate his director, page 2 🗌 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No ၉ 1 Tes ER/Outpatient 3 DOA 1 X Inpatient 2 After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? ours after death.

neral Director: Af
filled in by the fu 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER Day 3 2010 10:01 P M MARSHA CORMALETER MORGAN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 ☐ M 2 ☐XF Days Hours Min (Month, Day, Year) 4/29/1979 Months Country) Jamaica Director Yrs Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Clarendon 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be I Funeral New Ground District Summerfield PA Jamaica none within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 x No Specify Completed 3 Widowed 4 Divorced Specify. Jamaican 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th Domestic Worker Self-employed permit. Page 1 and 2 should be filed in Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Trevor Morgan Cynthia Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Drive Dale Henry/Brother Poughkeepsie, New York 12603 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Family Cemetery 9/11/2010 Clarendon, Jamaica Morgan Si n ure of Funeral Service Licensee 22. Name and Address of FacilityMarshall March Funeral Home Washington, DC 20011 4217 Ninth Street, NW of t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate nterval Between Inset and Death Inset L Immediate Cause (Final Physician -cell leukemic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Human T-cell leukemia virus 4 months Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy certificate 2 No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No Other: ျှ 1 🗌 Yes 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director; After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural 5 \square Pending work 1 🗌 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

DHMH 17 Rev 7/2009

State

within 2.

only one)

29b. Signature and title of certifier

<u>ALEXANDRA</u>

Alexandra Pratt, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated,

2010

CENTER DRIVE. BETHESDA. MARYLAND 20892

29c. License number D66239

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryla		artment of H		d Mental Hygie	2010	30555
	Physici /Medio		1. Recedent's Name (First, Middle, Last)		Mo	goon		2. Date of Death	Pag 2010	3. Time of Death
	Examir	er	4a. Facility Name (If not institution, give s The Johns Hopkins Ho	·		Ab. City, Town, or Baltimore		ath •	4c. County of Death	
	Funeral	Š.	Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under 24 H		9. Birthpl Countr	ace (State or Foreign
ŀ,	Director		219-92-4287 LSual Residence of Decedent	IVI 2 CAF	63 yrs.			Mar.17,	1947 Paki	istan .
	Maryland	tor	VA Fairfa		City, Town or Lo	cation			10	0d. Inside City Limits 1 ☐ Yes 2 🏋 No
	with the a or 28a be notifi	Director	10e. Street and Number 6319 Old Domin.	ion Dr		10f. Zip-Code 2210	1		Citizen of What Countr	y?
	ms 23	Funeral		12 Was Decedent Ever in	U.S. 13.	Was Decedent of Hill If Yes, specify Cubar			USA 14. Race - America	n Indian,
920	filed within 72 hours after death with the Maryland Hygiene Hygien that the With the West Saart show ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 XMarried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:		If Yes, specify Cubai 1 □ Yes 2 🏋 No	n, Mexican, Pue Specify:	erto Rican, etc.)	Black, White, et Asi	an
15-0	n 72 hou " natura edical E	Completed	15. Decedent's Edu (Specify only highest grade	completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired)	during most of w	/orking	b. Kind of Business/Ind	
212	ed withi giene. er than the M	Somp	Elementary/Secondary (0-12)	College (1-4 or 5+)		ker			Bakery	
Baltimore, Maryland 21215-0036	should be file nd Mental Hy s marked oth marked cth	To Be	17. Father's Name (First, Middle, Last) Ram Prakash Wa	san				lame (First, Middle, Maio alaya Ran		
Mary	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	r j	19a. Informant's Name/Relationship (Type Prem Prakash Ma		19b. Mailin	ng Address (Street a	and Number or minio n	Rural Route Number, Ci	ty or Town, State, Zip (IcLean, V	Code) A 22101
ore,	Pages 1 a nent of Hea nt: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ R	20b emoval from State	D. Place of Dispo cemetery, crer	sition (Name of natory or other place	Ser	Date 20c	Location - City or Tow	
<u>=</u>	permit. Pages Department of Important: If ii any injury or o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	T i	22	Memoria Memoria Home	s of Facility	airtax Me	Tairfax, emorial F	uneral
<u> </u>	Dep Imp any onc		> Brown all	~	Но	ome, 990	2 Brac	dock Rd.,	Fairfax,	VA 22032
	Physician /Medical Examiner	_	23a. Part 1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	ma m	uttiforme		ac or respiratory arrest,		Approximate Interval Between Onset and Death
,/60,	certificate be executed iding physician and use as the burial-transit	dical Examiner	if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events culting in death) Last	Due to (or as a conse	_					
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ב =	The ate has page	Com						autopsy performed′ 1 □ Yes 2 ☑	death?	pletion of cause of
VII al	sician: Th certificate irector, pa	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient 2	☐ ER/Outpatien	Other	P*	eath (Check only one) Home 5 Residence	6 Other (Specify)	
5	g Physer this neral d	n: 70	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		at	28d. Describe how in		
DINISION .	io the hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director.	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28e. Place of injury - At building, etc. (Spec	home, farm, stre	M 1 □ Y	es 2 No	28f. Location (Street City or Town, Sta	and Number or Rural	Route Number,
	# Hospita 24 hours # Funeral letely fille	edical C		cian: To the best of my kr er: On the basis of examir and manner stated.						
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		-	30. Name and address of person who co				000	- IUU	DIGINACI 10	12010
_	4		31. Date filed (Month, Day, Year)	Orth Ma 32. Registrar's Sign	nature		600	North Wolfe	St, Baltimore	e, MD, 21287
	Sta	.6	CED 4 E 2010		han Val					

DHMH 17 Rev 1/2001

10-06655 Zariyha Jacobs Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

riyha Jacobs	1	State of Maryland / Department of Health and Mental F	Hygiene	2010	30556
Physicia	7/	I-For State Registrar Amend#11PerFHPGC9-15-10CF 1. Decedent's Name (First, Middle,Last)	2. Date of Dear	eg. No.	3. Time of Death
edical Examin	er	Zariyah Hailey Miller-Jacobs	Month Septembe		1420 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat 6013 Springhill Drive # 203 Greenbelt	th	4c. County of Death Prince George'	s
Funeral Director	٦	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr Months Days Hours Mi	in	th(MM/DD/YYYY) 9. Birth Cou	nplace (State or Foreign ntry)
Director	-	Usual Residence of Decedent	5/27	/2010 Mar	yland
any	- 1-	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show 1 at once.	5	Md. Prince Georges Upper Marlboro			1 Yes 2XXNo
the N	Director	10e. Street and Number 216 Castleton Terrace 20774	1	0g. Citizen of What Count	ry?
tems 2.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (\$ 14. Never Married 2		14. Race - Americ White, etc.	an Indian, Black,
fter der fr., or i		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates:		Specify: bl	ack
hours a	eted by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		16b. Kind of Business/In	dustry
5-0036 led within 72 hours af Hygiene. Other than "matural the Medical Examin	Complet	Elementary/Secondary (0-12) College (1-4 or 5+) 0 none	,	none	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be င			Maiden Surname)	
2121 ould be fill I Mental F I marked		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	reace	mber, City or Town, State,	Zip Code) 20774
두 말씀 등록	L	Patreace Miller/mother 216 Castleton Te	rrace (Upper Marl	
Baltimore, permit. Pages I ar Department of Her Important: If the Injury or other tr		1 Burial 2 X Cremation 3 Removal from State crematory or other place)		Riverdal	,
Baltimore permit. Pages 1 Department of F Important: If injury or other	1	21. Sign-ture of Funeral Service center 22. Name and Address of Facility		al Mortuar	
E F D B W		411 Kennedy St	NW Was	shinton. D	C 20011
Physician /Medical	Į	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
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6 be exect ysician an burial - tr	ledical	UNPENDED AMENDED			
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Box 68760, c death certificate be the attending physic diffor use as the bur	Physician/N	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 9 Unknown			
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Vital F ysiclan: ysiclan: his certific	Be C	25. Was case referred to medical examiner? Hospital: I Inpatient 2 ER/Outpatient 3 DOA Other4 Nurs			
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tendin death. tor: A	cation	1 Natural 5 Pending Sep 3, 2010 0000 hrs 1 Yes 2 ✔ No	Baby assau		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found in apartment		Street and Number or Rui State) hill Drive # 203, Greenb	
To the Hosp within 24 hor To the Fune completely fi		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	nd due to the cau	se(s) and manner as state	ed. e cause(s)
To t with To t	Medical	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mor	
		California O.C.M.E.		September 4, 20	10
01	Ì	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner / 111 Penn Street, Baltimore, MD 2	21201	-	
St	ite	Zabiullah Ali, M.D. Assistant Medical Examiner / 111 Penn Street, Baltimore, MD 2 31. Date filed (Month, 2010) 32. Regist r's Signing.	. 1201		
Regist	-	CELL T & ALLE / BANKARA M. METT			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			F	rica	State	of Mary	land / Dep	artment	of H	ealth a	and Me	ntal Hyg	iene		0	00557
			State Registrar				Ce	rtificate	of E	Death			leg. Ne	201	U_	30551
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	/Medic	al	Sarah					4b. City.	ľown. or	Location o		эсрет.		. County of	Death	
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	Funeral		5. Social Security N		6. Sex	7. Age (li	n yrs. last birthday	If Under Months	1 Year Days	If Under a	Min	Date of Birth (Month, Day	Year)		Cour	
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	and	1	Usual Residence o 10a. State	10b. County		10	c. City, Town or L	ocation							1	0d. Inside City Limits
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	ath wi	ral	5555 Fr	iendshi	ip Blvd.		- 110	Was Dogge		0815	igin? (Spec	ifv Yes or No-	.	USA 14. Race	- Americ	can Indian,
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920	al", or	þ		4 Divorced	If Yes, C	Give -		1 □Yes	2 🔀 I No	Specify:				Specify:		nite
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Maryland	ild be fental rked c	To Be	Turner	G. More	ehead							Eliza				
ary	and N is ma	-	19a. Informant's f	Name/Relations	ship (Type. Print)							Route Numbe				
≥, ≤	and 2 lealth m 27 her tr	1		ttle/Ex	xecutor						NW , if		20c. L	Location - C	ity or T	OC 20016 own, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Mydral Example must be indiffed at once.			Cremation	3 K Removal from	m State	20b. Place of Disposer Commetery, or Metropol	ematory`or d itan	ther plac	ce)	9-14-	2010	A	lexan	dria	a, VA
Itin	artme ortant Injury		4∐Donation 21. Signature of §	5 ☐ Other (S			Cremator	Y 22. Name ar	nd Addre		9–14– ^{ity} De	Vol Fu				
Ba	permi Depai Impoi any Ir		1 ///	THE STAN	AM		2	222 W	isco	nsin	Ave.,	NW.,	Was	hingt	on,	DC 20007
			23a Part 1. Enter shock, or he	the disease, o	r compations that t only one cause or	at caused the n each line.	e death. Do not e	nter the mod	de of dyir	ng, such as	s cardiac o	r respîratory a	rrest,			Approximate Interval Between Onset and Death
	Physician		Immediate Cause disease or condit	tion	a	ementi							_			l½ years
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760,	be executed iclan and burial-transit		resulting in death) Last	Due	to (or as a	consequence of):									
3876	0 0	dical			d											
Box 68	Attending Physician: The law requires that the death certificate be executed reath. rector: After this certificate has been signed by the attending physician and by the tuneral director, page 2 should be detached for use as the burial-transit.	Completed by Physician/Medi	IF FEMALE: 23b. Was decede	ent pregnant	23c. If yes,		pregnancy Fetal death	3 ☐ Ectopic	pregnanc	cv				23d. Date		ivery Day Year
	death he atte	sicia	in the past 1 1 ☐ Yes	2 🔯 No	4 □ Pr			5 Other (s						14101		,
P.0	that the de ned by the	Phy	9 Unknov		tions contributing to	o death but	not resulting in the	underlying	cause giv	ven in Part	i.	23e. Did	tobacco	o use contr	ibute to	the cause of death?
ds,	signe d be d	d by		mic Lup								10	Yes	2 🔀 No	3□ Pr	obably 4 🗌 Unknown
202	w requires to been signal should be	letec										24a. Was		24b. V	Vere au	itopsy findings available completion of cause of
Re	rsician: The law s certificate has b lirector, page 2 sh	mo										perf 1 □ Yes	ormed?	? !	leath?	2 □ No
ita	ertifica ctor, p	BeC	25. Was case re examiner?	ferred to medic					T Ot			(Check only				
of V	Physic this or al dire		1 ☐ Yes 2 27. Manner of De			☐ Inpatien	t 2 ER/Outpa		28c. Inju	413(1		me 5 Res 28d. Describe				cify)
on (tending Pheath, lor: After the	tion	1 V Natural	5 Pend	/A	Month, Day,				ork? ⊒Yes 2[□No					
Division of Vital Records,	To the Hospital or Attendl within 24 hours after death, To the Funeral Director: A completely filled in by the the	Certification: To	3 Suicide 4 Homicid	6 Could	d not be mined 28e. PI	lace of Injur uilding, etc.	y - At home, farm, (Specify)	street, facto	ry, office			28f. Location City or To	(Street wn, St	and Numb ate)	er or Ri	ural Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical C	29a_Certifier (Check only one)	1 XCertify 2 Medica	ying Physician: To al Examiner: On the and r	the best on the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the ba	examination and/c	eath occurre or investigation	d at the	time, date opinion, d	and place, leath occur	and due to th red at the time	e cause e, date	e(s) and mand place,	anner a and due	s stated. e to the cause(s)
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	10		30. Name and a	ddress of perso	on who completed	cause of de	ath (Item 23a) (Ty	pe, Print)	٦ .	J C	to //O	n c:1-	767	Snrit	10	Md. 20002
			Linda	Burrell	, M.D.,	2/30	universi	ch RTA	a., b	v Sul	LE 40	O, DIT	A S T	Shiri	1B,	Md. 20902

DHMH 17 Rev 1/2001

Registrar

Modaber, Farah Aliolio @ 0300 Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Plea - For	ase Type or Pr AMEND IT State of M	i nt in Bl EM#1 pe laryland	ack In PrPHY Depa	delible Ink 5,6910,12 artment of H	Ensure 7 1 / 2010 lealth and	All Copie WS Mental Hy	es Are	e Leg	ible.	
		1 - State Registrar			Cen	tificate of D	eath		Reg. N	/ 11	10	30558
Physicia Medic		1. Decedent's Name (First, Middle Kheironesa Fara <u>Farah</u> <u>Mod</u>	h-Sadat l a ber	Behbaha	ani Mo	odaber		2. Date of D Month Septe	D	ay (0,	Year	3. Time of Death 0 3 500 Am
Examin		4a. Facility Name (if not institution) Shady Grove A	dventist Hos				Location of De			c. County Mont		ry
Funeral Director		5. Social Security Number 577-94-6725	4 🗆 14 0 🕅 e	ge (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	Irs. 8. Date of Bin. (Month, D	rth ay, Year)	908	9. Birth Cour	place (State or Foreign Iran
ryland r-f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. County	N	10c. City, To								10d. Inside City Limits
/ith the Ma 23a or 28s st be notif	Funeral Director	Maryland Monts 10e. Street and Number 299 Hurley Ave	gomery	Koc	kvill	10f. Zip Code 20850			_	itizen of V		•
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fune	11. Marital Status 1 Never Married 2 Marri	12. Was Decedent Armed Forces?	_	- 1	as Decedent of His Yes, specify Cuban		(Specify Yes or No erto Rican, etc.)	L	14. Race Blac	e - Americ k, White,	can Indian, etc.
2 hours af "natural" edical Exa	Completed		If Yes, Give Year or Dates. ht's Education st grade completed)	1	6a. Decede	Yes 2 X No ent's Usual Occupa ind of work done du	tion	vorkina	16b. F	Specify: Kind of Bu	Whi	
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and 2 sho Health and Im 27 is r her traun		19a. Informant's Name/Relationsh Parvaneh Modabe		r 5	105 Y	g Address (Street ar uma Ct.,			, DC	200	16	
L. Page 1 attent of Hant: If ite		20a. Method of Disposition 1 A Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ceme	etery, cremi onal l		Park 9		Fa	alls	•	own, State
permit Depari Impor any in	4 Donation 5 Other (Specify) National Memorial Park 9/13/2010 Falls Chur 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20											352
Physician/) Medical Examiner		23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	complications that caused nly one cause on each line a. Due to (or as	Э.			, such as cardi	ac or respiratory a	rrest,		3	Approximate Interval Between Onset and Death
te be executed ysician and ne burial-transit	dical Examiner	Sequentially list conditions, if any heading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to for acc. Due to (or asc.)		·							
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the b.	_	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	eath 3 🗀	Ectopic pregnancy Other (specify)				23d. Dati Mor		ery Day Year
uires that t n signed b uld be deta		Part II. Other significant condition Advanced			ng in the un	derlying cause give	n in Part I.					ne cause of death?
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or Attending Phy fter death. irector: After thi in by the funeral on	Certificate: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 Could r 4 Homicide determi	28a. Date of inju (Month, Day ation not be	ry (Year) 28b	o. Time of injury	28c. Injury a work? M 1 🗌 Yo		28d. Describe	how injur	y occurre	d	Route Number,
e Hospital of 24 hours a e Funeral D	Medical C	(Check 2 ☐ Medical Ex	Physician: To the best of caminer: On the basis of ex	xamination and	d/or investig	ation, in my opinion,	, death occurre	d at the time, date :	and place	, and due	to the cal	use(s) and manner stated
To th withir To th comp		29b. Signature and title of certification		2	inage, de	29c License r		77		te signed	(Month, I	
'		30. Name and address of person w	ho completed cause of de		a) (Type, Pri	nt)	ecula	r Dr.	Suit	e #.		Rockville
Stat Registra	_	31. Date filed (Month, Day, Year)	32. Registra	r's Signature		20						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ September 18 Darlene Canzeri Morse 2010 10:50a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 2 Queen Anne Avenue Dorchester Cambridge Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 1 M 2 X F Months Hours $Ju^{(Month)}_{V}1^{Day}$ Year) 948 New York Director 62 134-40-7753 Usual Residence of Decedent shov 10a. State 10b. County within 72 hours after death with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f
raumatic event, the Medical Examiner must be notifie. MD Dorchester Cambridge 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Queen Anne Avenue 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 þ 1 ☐ Yes 2 🔀 No Specify: white 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Joseph Canzeri Dorothy Frank permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard S. Morse husband 2 Queen Anne Avenue, Cambridge, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crematory of Delmarva 9/21/10 Delmar, DE 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St. Cambridge. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Metastahic Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant Day Pregnant at time of death 5 Other (specify) Month Year signed by the a d be detached f Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 10 24a. Was an autopsy perform Yes 2 funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Desidence 6 Other (Specify, 2 40 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne 1 Death 1 _____atural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending work? 1 ☐ Yes 2 ☐ No ours after death. neral Director: A filled in by the fu Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number

D 47924 29d. Date signed (Month, Day, Year) 9.21.2010 30. Name and address of person who completed duse of death (Item 23a) (Type, Print)

Registrar

State

THANWY

503

NOMAN

31. Date filed (Month, Day, Year)

57

CAMBRIDGE

MD 21613

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Physician/ 72010 1400 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, OCT. 9. 9. Birthplace (State or Foreign Age (In vrs. last birthday **Funeral** 1 🗆 M 2 🗷 F Hours MISSISSIPPI 93 1916 Director 437-18-4393 Usual Residence of Decedent show 10d. Inside City Limits or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 No MARYLAND QUEEN ANNE'S CHESTER 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number must be i Funeral UNITED STATES 244 BENTONS PLEASURE ROAD 21619 · death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, or than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc e filed within 72 hours after datal Hygiene.

dother than "natural", or in 1 Never Married 2 Married ğ Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Specify: WHITE 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER permit. Page 1 and 2 should be filed Department of Health and Mental Hy. Important: If item Z7 is marked other any injury or other traumatic event, once. event, å 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ ANNA ELLIOTT BISLAND EDWARD THOMPSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 244 BENTONS PLEASURE ROAD, CHESTER, MARYLAND 21619 RAWLE MANNIX/DAUGHTER Baltimore, 20b. Place of Disposition (Name of CHESAPEARE) CREMATION CENTER 20c. Location - City or Town, State 20a. Method of Disposition Date SEPT 2010 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. 21619 MARYLAND 106 SHAMROCK ROAD, CHESTER, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TAPIT SEPSIS Physician/ disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner 1/1 UNTH) equentially liet our difference if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) executed burial-transit Due to (or as a consequence of): physician s the burial Physician/Medical that the death certificate be Box 68760 ding p IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? for Month Year Other (specify) Pregnant at time of death signed by the a P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, or Attending Physician; The law requires Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy has performed death? 1 🗌 Yes 2 🗆 No this certificate 2. No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No Inpatient 2 ER/Outpatient 3 DOA မြ eral Director: After th filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural
2 Accident
3 Suicide
4 Homicide injury work? 1 ☐ Yes 2 ☐ No 5 \square Pending hours after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C completed filled the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifie 37010 Name and address of person who completed cause of death (Item 23a) (Type, Print) VICH ATL ENTA MO du ENSC

Registra

State

31. Date filed (Month, Day, Year)

SEP

14

Registrar's Signature

Please Type or Print in Black Indelible/Ink/15 naure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 30561 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 201/005:23 Moses CHAYISA ()6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Northampton Manor Nursing Home Frederick Frederick If Under 1 Year | If Under 24 Hrs. | Date of Birth (Month, Day, Sep 1, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country). 6. Sex **Funeral** Days МD 1 □ M 2 □ 🕊 91 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Itama 23a or 28a-f show Examper must be pullified at Morgan Berkeley Springs 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 240 Swain Lane 25411 USA deeth v Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Btack, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural', or Itan any injury or other traumatic event, the Medical Examinations. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) LPN Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hugh W. Meese Bertha (Getson) Meese 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
240 Swain Lane Berkeley WV 25411 19a Informant's Name/Relationship (Type, Print) Francis Footen Son 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State St. Michael's Cemetery 9/27/2010 Frostburg MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name Scarpell Pfameral Home, PA come 108 Virginia Avenue: Cumberland, MD 21502 TUN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mintes STROKE /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. physician the attending pl TE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records. 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 1 🗌 Yes death. investigation 2 Accident after deat Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled in within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D43091 9-22-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick MD 2174 House Ave 102 TOLL and, MA 31. Date filed (Month, DaySEP 2 Registra s Signature

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Patricia Joyce Angelina Most Physician/ September 2010 8:10 P^{M} Medical 4a. Facility Name (if not institution, give street and number)
University of Maryland Medical Center Town, or Location of Death Baltimore 4c. County of Death Examiner Social Security Number 249-40-7518 8. Date of Birth (Month, Day, Year) April 17, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2XXF Months North Carolina 80 Director 193d Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland thin and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at the most be notified at the Medical Examiner must be not the Medical Examiner must be notified at the Medical Exami 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1585 Long Point Road 21122 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify: Completed 3℃Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Susie May Greemon 2 Torrence F. Pettus 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1585 Long Point Road Pasadena, Maryland Nancy Jeanne James/daughter injury or other 20a. Method of Disposition permit. Page 1 a
Department of H
Important; If ite
any injury or ott 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State Baltimore Crematory 9/14/2010 |Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fyneral Service 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ Asystole disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Intracranial hemorrhage 20 hours Sequentially list conditions Examine if any, leading to immediate cause. Little Unicertying Cause (Disease or linjury that initiated apparts Due to (or as a consequence of): Hypertension that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Pregnant at time of death 1 Yes 2XXNo cate has been signed by the page 2 should be detached g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate has Hospital or Attending Physician: The 24 hours after death. 1 ☐ Yes 2 ☐ No Yes 2 🔀 No **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2XXNo ပ္ 1 M Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1XX Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide completed filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Contifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 29c. License numbe 29d. Date signed (Month, Day, Year) 100554 September 9, 2010 cesid en 114 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Akil Patel, MD 22 South Greene St. Baltimore, Maryland 31. Date filed (Month, Day, Year) SEP 13 2010 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death eptember Day Month, Physician/ 1:10 AM 2010 Annie Rutland Mason Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Prince Regional Laurel Laure George's 5. Social Security Number Year If Under 24 Hrs If Unde 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 1 □ M 2 👿 F Months Hours 89 418–12–7273 Director October 24. 1920 Alabama Usual Residence of Decedent items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21043 5502 Fox Tail Lane 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Mae Adams Samuel F. Rutland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5502 Fox Tail Lane, Ellicott City, Maryland 21043 Gail A. Mason - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🕅 Burial 2 🗆 Cremation 3 🕅 Removal from State 09/11/2010 Melbourne, FL Melbourne Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 MO1283 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Just only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final-Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami and I-transit requires that the death certificate be executed resulting in death) Last physician a Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
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5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 Yes 2 9 Unknown ed by the a 9 Unknown P.O. s been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed s certificate has lirector, page 2 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2V No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Beath 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Division 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month D70093 7300 Van Dusen Rd: ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre

Registrar

State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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O.C.M.E. September 13, 2010 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	To tl withi To th	Medi		and manner stated.	A	.conyanor			at the time, date :		
30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	12		9/ th 5/ ft	-6)///	3,00	50	1				
Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	,		30 Name and address of person who as	moleted cause of death	(Item 23a)					357.3	-,
						111 Per	nn Street,	Baltimore,	MD 21201		
			31. Date filed (Month, Day, Year)	32 Registrar's S	ignature	base	1				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar 30565 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 22 Milton 0sborne 2010 0300 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 E1kton Laurelwood Care Center 8. Date of Birth June 24, 1925 Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F North Carolina Ju<u>ne</u> **Director** 238-30-5740 85 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director E1kton 1 Tes 2 X No Maryland Ceci1 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 10 Norman Allen Street 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 🔀 Married þ 1 V Yes 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 1947-51 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Automobile College (1-4 or 5+) Elementary/Seconday (0-12) Manufacturing Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Belle A. Nelson Milton Osborne Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen V. Osborne/Wife 10 Norman Allen St., Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 25 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 2010 4 Donation 5 Other (Specify) Gilpin Manor Memorial Park Elkton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

a Cancer of Bladder with Metastasis Approximate Interval Between Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? for Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown cate has been signed by ; page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title # certified Sachder-s. MD D0023322 9.22.2010.

State Registrar

Electon MD 21921

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

SACHDEN MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10^{Day} SEPT Physician/ 201^{Yea} REGINA BRENNAN ORIGONI 8:25A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death POOLESVILLE MONTGOMERY 17300 EDWARDS FERRY ROAD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 6. Sex Age (In vrs. last birthday 8. Date of Birth **Funeral** Days 1 □ M 2 🖭 Months Hours Min 0 4^Mmin87149127 202-20-9839 83 Yrs. **Director** Usual Residence of Decedent 28a-f shov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD MONTGOMERY POOLESVILLE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17300 EDWARDS FERRY ROAD 20837 USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc δ 1 Never Married 2 Married Maryland 21215-0036 Specify:WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CHEMIST PHARMACEUTICAL 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 MART F. BRENNAN ELIZABETH C. HIGGINS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) VICTOR ORIGONI / 17300 EDWARDS FERRY RD., POOLESVILLE, **SPOUSE** Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State netery, crematory or other place)
MARY S CEMETERY ST. BARNESVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility P.O. BOX 86 A HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician MULTIPLE MYELOMA years disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed 2 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 2 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify After this 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32407 09/13/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar JOSEPH MI HAGGERTY,

31. Date filed (Month, Day, Year)

10

9707 MEDICAL CENTER DR.,

ROCKVILLE, MD

20850

MD

32. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ P^{M} OLAWALE SEPTEMBER 2010 BERNICE Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. (Month, Day, Year Country) 1 □ M 2 🛛 F Months Hours 1961 NIGERIA **Director** PRIL 10 49 769-24-4011 Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10b. County within 72 hours after death with the Maryland items 23a or 28a-f sho her must be notified at 10a. State Director 1X☐ Yes 2 ☐ No PRINCE GEORGE'S UPPER MARLBORO MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral 243 HARRY S TRUMAN # 13 20774 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status raf", or iter Examiner Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify: BLACK If Yes, Give Specify: "natural" 3 Widowed 4 Divorced Year or Dates. Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) Mental Hygiene. narked other than College (1-4 or 5+) Elementary/Seconday (0-12) the HOUSEWIFE 12TH PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev should be SHOGBEINDE OLAWALE KIYESOLA POPOOLA .nc. Page 1 and 2 shou...
** of Health and Me
** of T is mr
** 77 is mr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2077419a. Informant's Name/Relationship (Type, Print) TRIMAN UPPER MARLBORO, MARYLAND OLASOJI R. OLAGUNJU/SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) FAMILY PLOT 12/10/2010 IBADAN, NIGERIA 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME Signature of Funeral Service Ligense 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval Between 23a. Part 1. Enter the disea Onset and Death Immediate Cause (Final SEVERE ACUTE PANCREATITIS Ph sician/ resulting in death) Medical Due to (or as a consequence of): Examiner ACUTE RENAL FAILURE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). ACUTE LIVER FAILURE To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown HIGH BLOOD PRESSURE Records, Completed 24b. Were autopsy findings available 24a. Was an TYPE II DIABETES MELLITUS prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 😿 No Yes 2X□ No Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 **□X**No 1 X Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Lactifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 _ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

yen

32. Registrar's Signature

30. Name and addreds of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

6 2010

D41752

BERGIT I. SCHOELLMANN M.D. 1500 FOREST GLENN ROAD SILVER SPRING, MARYLAND 20910

SEPTEMBER 10, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 _ State	State of Maryland		rtment of H tificate of L			giene Reg. No. 201	0	30568
	Physici	an	Registrar 1. Decedent's Name (First, Middle, Last)	, DTUUT OUT (imouto or E		2. Date of De	ath		3. Time of Death
	/Medic Examin	cal	WILLIAM FRANK 4a. Facility Name (If not institution, give s		SR.	4b. City, Town, or	Location of Death	sept.	21, 2010 4c. County o		10;00P M
	Examin	ier	14805 KING C	HARLES DRIVE		SWAN	POINT		CHARL	ES	[1]
E	Funeral Director		5. Social Security Number 6. Sex 188–32–1111	M 2□ F 7. Age (In yrs. la 70		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 8 – 5 – 1	9 4 0	9. Birthpla PA •	ace (State or Foreign ry)
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation				10	d. Inside City Limits
	e Maryl ka-f sho	ctor	MD. CHARLES	5	5	SWAN PO	INT				1 □Yes 2 No
	with the	I Director	10e. Street and Number 14805 KING CHAI	RLES DRIVE		10f. Zip Code	0645		10g. Citizen of WI	nat Counti	ry?
	r death	Funeral		Was Decedent Ever in U.S. Armed Forces?	. 13. W	as Decedent of Hi Yes, specify Cuba		pecify Yes or No o Rican, etc.)		- America	
036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the "McCeal Exprision" curst be neithful at	Ş	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1		□Yes 2X No	Specify:	, , , , , , , , , , , , ,		WHIT	
15-0036	"natura	Completed	15. Decedent's Educi (Specify only highest grade	ation completed)	(Give k	ent's Usual Occupa	luring most of wor	king	16b. Kind of Bus	iness/Indi	ustry
2121	filed within Hygiene. other than "	omo	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		O NOT use retired, ES REPRI		IVE	HVAC		
Maryland	the filed intal Hygined ed other sevent, it	Be	17. Father's Name (First, Middle, Last) FRANK EDWARD I	OTKIII.SKT					Maiden Surname		
ary	s 1 and 2 should be to the feath and Mental item 27 is marked oother traumatic eve	ဥ	19a. Informant's Name/Relationship (Typ	e. Print)		Address (Street a	and Number or Ru	ral Route Numb			Code)
Φ	1 and 2 Health em 27 i		DOROTHY PIKULSI 20a. Method of Disposition			KING (CHARLES	DR .	SWAN PO		MD.20645
Ē	Pages nent of int; If its iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	ernoval from State TRINI	metery, crem TY ME	atory or other place	ens 9-2	5-10	WALDORF	•	·
Baitimore,	permit. Pages Department of Important; If it any injury or o		21. Signature of Edneral Service License			Name and Addres		SERVI	CE, P.A.		
		£ 11.	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	ations that caused the death.							Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	to (or as a conseque	ence of):	700	ally				
	Examiner	-	Sequentially list conditions, b.	Due to (ur as a sonseque	8 d	7-7	54.5				
	scuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		31,00 01,						
Ď O	eath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):						
09/89		Medical	d.						Т		
C. BOX	000	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Bc. If yes, outcome of pregnan- 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of deans 9 ☐ Unknown	death 3 🗌	Ectopic pregnancy Other (specify)	′		23d. Date Mon		ry Day Year
7.	law requires that the de as been signed by the a 2 should be detached f		9 ☐ Unknown Part II. Other significant conditions cont		ting in the und	derlying cause give	en in Part I.	23e. Did t	obacco use contrib	oute to the	e cause of death?
ecords,	w requires been sign should be	ed by						10	∕es 2 🗍 No 3	∃∏ Proba	ably De Unknown
- GC	e law re has be je 2 sho	Completed						24a. Was	sy pr		sy findings available apletion of cause of
VITAL	ding Phystcian; The law h, After this certificate has funeral director, page 2 s	Be Co	25. Was case referred to medical				26. Place of Dea	1 □Yes	2 No 1	Yes 2	2 □ No
010	Physic this ce al direc	ပ္	To les Election	ospital: 1 Inpatient 2 E			r: 4 🗆 Nursing H	ome 5 AResi	dence 6 □Othe	1 , , , ,)
VISION	nding ath. r: After e funer	ation	27. Manner of De th 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work M 1 □ Y	rat ? ′es 2∐No	28d. D#scribe l	now injury occurred	1	
DIVIS	after des after des Director d in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stree	et, factory, office		28f. Location (S City or To	Street and Number vn, State)	r or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death, To the Funeral Director: After this certifica completely filled in by the funeral director, p	edical C	29a. Certifier Certifying Physic (Check only one)	ician: To the best of my know er: On the basis of examination and manner stated.	ledge, death on and/or inve	occurred at the timestigation, in my op	ne, date and place pinion, death occu	e, and due to the rred at the time,	cause(s) and mar date and place, ar	nner as stand due to	ated. the cause(s)
	To th To th	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed	(Month, D	lay, Year)
			30. Name and address of person who con	npleted cause of death (Item 2	23a) (Type, P	rint)_	5).		11+	114	
			60	BOX	170	3	lapla	Ja	MD	2	0646
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	A	booked					

DHMH 17 Rev 1/2001

			For State Registrar	State o	f Marylan		artmen <i>tificate</i>			nd Ment		ne 20	0	30569
Phy	ysicia	n/	1. Decedent's Name (First, Middle, La	•	- 1						ate of Death		ear	3. Time of Death
	ysicia Medic kamin	al	4a. Facility Name (if not institution, giv		Palmer 4b. City, Town, or Location of Dea			SEP	TEMBER		010	3:44 PM		
, - -	Karmın	er	Washington County Hospital				Hagerstown				Washing		iton	
	neral ector		5. Social Security Number 6. S 214-16-0664	Sex □M2√F	7. Age (In yrs. Ia 88	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours		te of Birth Jonth, Day, Ye	ar) ,1922	Birthp Count Mar	lace (State or Foreign ry) ryland
land	dat	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loc							11	0d. Inside City Limits
e Mary	notifie	Funeral Director	Md. Washington Hage 10e. Street and Number				rstown				100	10g. Citizen of What Country?		1 Yes 2 □ No
with th	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	eral	55 E. Washington St. Apt. 510				21740				109	U.S.A		
after death		þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed For 1 Yes If Yes, Giv	2 🔀 No e	S. 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Po			n? (Specify Ye Puerto Rican,	pecify Yes or No- to Rican, etc.) 14. Race - Black, Specify:				
72 hours		Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G				cedent's Usual Occupation ve kind of work done during most of working . DO NOT use retired)				16	16b. Kind of Business Industry		
4 within ygiene.		To Be Con	Elementary/Seconday (0-12)	College (1-	-4 or 5+)		aitre	ess				Restau	rant	
be filec			17. Father's Name (First, Middle, Last) Fr ank M. $Spigler\ Sr$.				18. Mother's Name (First, Middle Ethel B. K					,		
12 should alth and N			19a. Informant's Name/Relationship (Type, Print) Shirley A. Fox (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 515 Rhode Island Ave. Hagerstown, Md. 21740											
Page 1 and lent of Hei			20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		State C	Place of Disposemetery, crem	natory or of	ther place		pt. 22	2, 2010	c. Location - C Smi		wn, State ourg , Md .
permit. Popartir	any inju		21. Signature of Funeral Service Licer	see	MO14				of Facility Funer	al Hon	1252 ne Smit	25 Br a d thsburg	bury ,Md.	Ave. 21783
		-	23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	plications that cone cause on ea	aused the death	h. Do not ente	r the mode	of dying	, such as ca	ardiac or respi	ratory arrest,			Approximate Interval Between Onset and Death
	dical		disease or condition resulting in death)	a. Due to (or as a consequ	ience of): ~	~		on	. S V	1COM	stem	+	
Exan	iner	Jer	Se quentially list conditions if any, leading to immediate	b. Due to (or as a consequ	ience of):	n						-	
ecuted	has been signed by the attending physician and je 2 should be detached for use as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of):											
ate be executed		edical E	d.											
th certific		Σ	IF FEMALE: 23b. Was decedent pregnant in the past 12 monute? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 📙 Pregi	1 Live Birth 2 Li Fetal death 3 Li Ectopic prégnancy						Date of delivery Month Day Year			
quires that the		ا ۾	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown											
aw requi		Completed	History of	y of Serzue							4a. Was an autopsy			osy findings available
The la	ral director, page 2	_	Covenay an	Tey	Pisce	se				> 1	performed Yes 2	d? dea	ith?	2 🗆 No
ysician s certif	directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2 🗆	ER/Outpatien	t 3 🗆 DC	Other		(Check only only only only only only only only		e 6 🗆 Other (Specify)	
ling Phy	To the Funeral Director. After this completed filled in by the funeral of		27. Manne Death 1				28c. Injury at work? M 1 Yes 2 No 28d. De 28d. De 28d. De			28d. D	28d. Describe how injury occurred			
or Attence after death		Certificate:								cation (Street and Number or Rural Route Number, y or Town, State)				
the Hospital hin 24 hours the Funeral		Medical	29a. Certifier (Check only one) 1											
~ 70 Withir To th			29b. Signature and title of certifier 29c. License number 29d. Date signed (Month											
			Junior December 16, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 E. Antietam 51											
			Francisco A	Dan	iels 1	D0	K	09	est.	NU 6	MI	2 21	74	8
-	Stat		31. Date filed (Month, Day, Year) —		egistra 'e Signat	ture &	ha	No 8						

DHMH 17 Rev 7/2009

		1 _ State	State of Maryland / De	partment of He <i>ertificate of D</i>		Hygiene Reg. No. 2010	30570						
	-	Registrar 1. Decedent's Name (First, Middle, Last)		Crimoate of B	2. Date of		3. Time of Death						
Physic			D 1		Month	Day Year							
/Medi		David Ostrow Solo 4a. Facility Name (If not institution, give s		4b. City, Town, or Lo		mber 7, 2010 4c. County of Deat	11072 1						
Examii	ner												
Funeral		Holy Cross Hospita 5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	Silver S	If Under 24 Hrs. 8. Date of	Birth Day, Year) 9. Birth Co	hplace (State or Foreign						
Director		224 − 13 − 7593	M 2□F 49 Yrs	Months Days	Hours Min. (Month, 11/15	5/1960 MI	71960 MT						
2 ,		Usual Residence of Decedent											
shov	_	10a. State 10b. County	10c. City, Town or			10d. Inside City Limits							
8a-f	Director	Montgom Montgom	ery Colle	ege Park			17 Yes 2 □ No						
5 2		10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	untry?						
s 23	Funeral	4711 Berwyn House			740	USA							
item	5	THE MARKET GRACES	3. Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Specify Yes or Mexican, Puerto Rican, etc.)	No- 14. Race - Ame Black, White								
, o	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 💢 No	Specify:	Specify:								
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner must be notified at once.	ed	15. Decedent's Educ	Year or Dates:	ecedent's Usual Occupati	ion		White 6b. Kind of Business/Industry						
	Completed	(Specify only highest grade	completed) (G	ive kind of work done du e. DO NOT use retired)									
	E	Elementary/Secondary (0-12)	College (1-4or 5+)	unication R	esearcher	Communio	rations						
	Be C	17. Father's Name (First, Middle, Last)	Z		8. Mother's Name (First, Mid								
	To B	Jack Edward Pulwe	rs. Sr.		Ethel Owens								
	-	19a. Informant's Name/Relationship (Typ		ailing Address (Street an		ural Route Number, City or Town, State, Zip Cod							
	١.,	Dr, Jack Pulwers,	Sr. / Father 41	16 Mount Fo	ho Lane Fairf	av Virginia	Jirainia 22022						
Item othe		20a. Method of Disposition	20b. Place of Di	sposition (Name of	Date	20c. Location - City or							
nt: If		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	Cimoval from State	rematory or other place)	i		-1. L - MD						
ortal Inju		21. Signature of Funeral Service License		22. Name and Address	09/13/2010	JICapitol Hei	gnts, MD						
any Ir		11/061	2 Kurt Blake	Danzansky-(of Facility Goldberg Memo: lle Pike Rock	rial Chapels ville, MD 208	inc.						
		2. Part 1. Enter the disease, or o implic	ations that caused the death. Do not				Approximate						
cioian		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.				Interval Between Onset and Death						
sician edical		disease or condition resulting in death)	Urosepsis Due to (or as a consequence of):										
niner				Urarathu									
	ē	Sequentially list conditions, if any, leading to immediate	Obstructive Due to (or as a consequence of):	Olopathy									
aus.	Examiner	Cause (Disease or injury that initiated events	Chronic Kidn	ev Disease									
burial transit	Exa	resulting in death) Last	Due to (or as a consequence of):	<u> </u>									
ysician e buria	cai	d	Bladder Canc										
g phy as thi	edi												
nse	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy	-0		23d. Date of de	livery						
in the tracking of statements of the same requires that the death centilicated for the Funeral Lifector. After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			Month	Day Year						
	hys	9 🗆 Unknown	9 □ Unknown										
	by P	Part II. Other significant conditions con-	tributing to death but not resulting in th	in Part I. 23e. D	oid tobacco use contribute to	the cause of death?							
g pla	p p	Thrombocytoper	ria		1	1 ☐ Yes 2 ☐ No 3 ☐ Probably							
s been si	Completed				24a. V	Vas an 24b. Were a	utopsy findings available						
ige 2	ᇤ				a	utopsy prior to erformed? death?	completion of cause of						
or, pe	Ö	25. Was case referred to medical			1 □ Y€		2X No						
lirect	m	eyaminer?	ospital: 1X Inpatient 2 ☐ ER/Outpa		26. Place of Death (Check or	ath <i>(Check only one)</i> Home 5 ☐ Residence 6 ☐ Other <i>(Specify)</i>							
<u></u>	0 ::	27. Manner of Death	28a. Date of Injury 28b. Tim	Ment 3 DOA	4 Industrig Horne 5 I F	Residence 6 ∐Other (Spe ibe how injury occurred	iciiy)						
5 00	tiol	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Inju	ry Work?	es 2 No	f. Location (Street and Number or Rural Route Number,							
funera	ca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm,										
y the funera	=	4 ☐ Homicide determined	building, etc. (Specify)	22, 110,0,1,0,1100		Town, State)							
In by the funer	ertifi			eath occurred at the time	e, date and place, and due to	the cause(s) and manner a	s stated.						
filled in by the funer	al Certification:	29a. Certifier 1X7 Certifying Phys	ician: To the best of my knowledge id	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due one one)									
e runeral unrector After etely filled in by the funera		(Check only 2 Medical Examin	ician: To the best of my knowledge, d er: On the basis of examination and/o and manner stated.	r investigation, in my opi	nion, death occurred at the ti	ine, date and place, and du	e to the cause(s)						
o the Funeral Director After ompletely filled n by the funera	Medical Certifi	(Check only 2 Medical Examin	er: On the basis of examination and/o	29c. License		29d. Date signed (Moni	e to the cause(s)						
completely filled in by the funeral		(Check only 2 Medical Examin	er: On the basis of examination and/o	29c. License ı	number	29d. Date signed (Mon	th, Day, Year)						
completely filled in by the funeral		(Check only 2 Medical Examinone) 29b. Signature and title of certifier	er: On the basis of examination and/o and manner stated.	29c. License i	number		th, Day, Year)						
Completely filled in by the funeral director, page 2 s		(Check only 2 Medical Examin	er: On the basis of examination and/o and manner stated. mpleted cause of death (Item 23a) (Type	29c. License r D5514 pe, Print)	number 8	29d. Date signed (Mon-	th, Day, Year)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 0 3057 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sol Pargament September 2010 1:45 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Washington, DC **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Days Min. 1 X M 2 - F 578-20-4225 Yrs. **Director** 88 Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Silver Spring chrm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15107 Interlachen Drive, #724 20906 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. 1 Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3X Widowed 4 □ Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be filed f Health and Mental H item 27 is marked ot ည Morris Meyer Pargament Rebecca Bloomberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcia Goldmark, daughter 4823 Hornbeam Drive, Rockville, Maryland item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit, Page 1 Der artment of I Important: If ite any injury or of cemetery, crematory or other place)
King David
Memorial Gardens 1 🕅 Burial 2 🗆 Cremation 3 🗓 Removal from State 4 Donation 5 Other (Specify) 09/12/2010 Falls Church, Virginia 21. Signature of Juneral Service Licenses Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland MO1255 23a. Part 1 Enter the Issease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death -Physician/ Multi-System Organ Failure Hours Medical resulting in death) Due to (or as a consequence of) Examiner Acute Right Coronary Artery Dissection Hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying I-transit Cause (Disease or linjury that initiated events resulting in death) Last death certificate be executed Acute Inferior Wall Myocardial Infarction Hours Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Three Vessel Atherosclerotic Coronary Artery Disease the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death asn 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ٰ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? Yes 2 X No certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 Yes Other: 21 No ဂ္ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending work? injury XNatural 5 Pending thin 24 hours after death.

the Funeral Director: A mpleted filled in by the fu death. Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my individedge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie To the I within 2 only o Signa 29c. License number 29d. Date signed (Month, Day, Year) D0038159 September 10, 2010

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

Division of Vital

Dr. Philip Charle's Corcoran, 8600 Old Georgetown Road, Bethesda, Maryland

20814

Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Sept 14, Physician/ 2010 1:22 A.M.M Poole, II Olin D. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George Clinton g. Birthplace (State or Foreign Social Security Number 6. Sex If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Months Days Hours June 17, 1XX M 2 □ F Washington DC 76 577 44 3443 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2XX No Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral United States 2416 Kenton Place 20748 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2XX Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XXNo Specify: 3 Widowed 4 Divorced White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sheet Metal Worker Union 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Elsie Alexander Olin D. Poole, I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Poole (Wife) 2416 Kenton Place, Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery Sept 18, 2010 Annapolis, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Licensee Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arm shock, or heart failure. List only one cause on each line. Approximate terval Between set and Death Immediate Cause (Final end Stage Physician/ rea Medical resulting in death) Due to (or as a consequence of) Examiner 2002 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine 2002 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned to the action. Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transit MYO Card years Physician/Medical hvomic Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by bladder Neuvorenic 1 Yes 2 PNo 3 Probably 4 Unknown pu (monary 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page Chronic performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗹 Natural 5 Pending work? 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29b. Signature and title of certifie D0042049 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) upper Marlboro. MD. 20772 HAMFA LOUX

State Registrar 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician Jan 15 2:35 AM een 2010 ulia EPT /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ester COX eci RUCEN If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours -14-4958 1 □ M 2 🕱 F Mary land Director Usual Residence of Decedent death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f sho 1 Yes 2 No Director Hunes 10e. Street and Number 10g. Citizen of What Country? 10f Zip Code 1010 COX NECK 21619 SA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No Specify: Black ģ 3 NWidowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Şecondary (0-12) College (1-4or 5+) Sera State ean permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygle Important: If Item 27 is marked other thany injury or other traumatic event, I'm 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SSie oane ပ 1e 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) entreville MD 21617 Joan Baltimore, 20c. Location - City or Town, State Date 20a. Method of Disposition Chester, 1 Burial 2 □ Cremation 3 □ Removal from State 111/2010 4 ☐ Donation 5 ☐ Other (Specify) Funeral Homei PA. 22. Name and Address of Facility Henry 21. Signature of Funeral Service Licenses MD21613 510 Washington 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 2 → 10 3 □ Probably 4 □ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has autopsy certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 **** 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of con 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinte ANNAPOLIS ABRAHAM 400 21401

State Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

		Please I	State of Maryland					_	e.		
	-	For State	State of Maryland	•	tificate of L			201	30574		
		Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Death	9/ 1101	3. Time of Death		
Physicia: Medic		Mary Delore			Septembe	er 7, 201	0 6:45 A. M				
Examine		4a. Facility Name (if not institution, give street and number) Washington Adventist Hospital			4b. City, Town, or Location of Death Takoma Park			4c. County of Death Montgomery			
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9.	Birthplace (State or Foreign Country)		
Director		215-32-5447 Usual Residence of Decedent	M 2 M F 74	Yrs.			May 27,	1936	Maryland		
and show	ρ	10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits		
Mary 28a-f otifie	irec	Maryland Prince (Georges E	lyatts					1 Ves 2 □ No		
th with the Maryland ms 23a or 28a-f show must be notified at] [3]	10e. Street and Number	7		10f. Zip Code 2078:			ig. Citizen of What United St			
ath wi	Funeral Director	803 Rittenhouse S	2. Was Decedent Ever in U.S.	13. V		lispanic Origin? (Spe			merican Indian,		
ter de or ite	by F	1 ☐ Never Married 2 X Married	Armed Forces? 1 Yes 2 No	If	Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, W			
urs af tural", al Exa	ted	3 Divorced	If Yes, Give Year or Dates.					Specify:	Black		
72 ho n "nat ledica	Completed	15. Decedent's Edu (Specify only highest grade	completed)	(Give k	ent's Usual Occup aind of work done of NOT use retired)	during most of work	ing 1	6b. Kind of Busine	ss Industry		
vithin jiene. r tha		Elementary/Seconday (0-12)	College (1-4 or 5+) years		istered 1			Medica	1		
permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma				
lld be Menta arked atic e	욘	Walter Parker				Eliza	beth J	ohnson ————			
shou h and 7 is m traum		19a. Informant's Name/Relationship (Type				and Number or Run					
and 2 Healt tem 2		James Alvin Pettus 20a. Method of Disposition			sition (Name of			Oc. Location - City	yland 20783 or Town, State		
age 1 ent of nt: If ii y or o		1	emoval from State cei	metery, crem	natory or other place.coln Cem		.14,		l,Maryland		
mit. P partm portar / injur		21. Signature of Funeral Service Licensee	/ /			<u> </u>			Morticians,		
De and and and and and and and and and and		Landaloh	B. How	In	c.;600 K	ennedy St	reet,N.W	.;Washing	gton,D.C.20011		
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Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	SEATIC	SHOC	K				Onset and Death		
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	cal E	resulting in death) Last	Due to (or as a conseque		NACIO	Œ					
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requires that the death certificate been signed by the attending phys should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnan		1 –			23d. Date of	delivery		
d for u	sicia	in the past 12 months? 1 ☐ Yes 2 No	1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnand Other (specify)	cy		Month	Day Year		
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requir	etec				-		24a. Was an		autopsy findings available		
e law e has l ge 2 s	Completed						autopsy perform	prior	to completion of cause of 1?		
rsician: The law I s certificate has b lirector, page 2 s	Be Co	25. Was case referred to medical			26. P	lace of Death (Chec		No 1 □	Yes 2 No		
lysicie is cer direct	To B	examiner? 1 Yes 2 No	ospital:	R/Outpatien	nt 3 🗆 DOA Oth	er: 4 \(\sum \) Nursing He	ome 5 🗆 Residen	ce 6 Other (S	pecify)		
ng Ph fter th ineral	ate:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injur work	k?	28d. Describe how	injury occurred			
death death tor: A the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	One Place of Injury. At hom	as form atra		Yes 2 No	OOF Leasting Office	28f. Location (Street and Number or Rural Route Number,			
after a Direc	Cer	4 Homicide determined					City or Town,		nurai noute Number,		
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying Physic	ian: To the best of my knowle	dge, death c	occured at the time	e, date and place, a	nd due to the cause	e(s) and manner as	stated.		
the Ho nin 24 the Fu	Med	only one) 3 Certifying Nurse	r: On the basis of examination Practioner: To the best of my	and/or invest knowledge, c	leath occurred at th	ne time, date and pla	ce, and due to the c	ause(s) and manner	as stated.		
To with		29b. Signature and title of certifier			29c. Licens			d. Date signed (Mo	onth, Day, Year)		
•		Cardi Vill	aplated paying of death (the-	23a) /Ture = 1	1204	7751	2	-41 0-1134)		
2		RANDAU WACHE	hpleted cause of death (Item 2			oms Par	K MD	20	912		
Stat	е	31. Date filed (Month, Day, Year)	32. Registrar's Signatu		-						
Registra		SEP 1 5 2010 Den	we p. you	Red							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30575 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day September 8, 2010 1:15 PMM Stephen Patchan, III 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery 4103 Spruell Drive Kensington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Days Hours Min. Jan. 17, 1925) 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) 1 1 X M 2 □ F 191-18-9398 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No MD Kensington Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20895 4103 Spruell Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1x Yes 2 □ No 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 1 No Specify: Specify: White 3 ☐ Widowed 4 🙀 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DC Government DC Examiner of Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Walko Stephen Patchan, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8407 Alameda Court, Alexandria, VA 22309 19a. Informant's Name/Relationship (Type. Print) Stephen Patchan/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Sept. Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2010 Alexandria, VA 21. Signature of Funeral Service Licenses 22 Name and Address I failly Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DME disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 □Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No

/Medical **Examiner** Box 68760, the death certificate be P.O. F of Vital Records, Division

physician and s the burial-trans attending p for use as 1 as signed by the a cate has t page 2 s certificate the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After the Completely filled in by the funeral

Physician

/Medical

Director

Funeral

Completed

Be

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Examiner

Physician/Medical

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Examiner

Funeral

Director

item 27 is marked other than "natural"; or Items 23a or 28a-f show other traumatic event, Its Medical Exp. direct mast be retified at

the Maryland

within 72 hours after death

ould be f Mental

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other transment.

Physician

Baltimore, Maryland 21215-0036

Completed Be ၉ Certification: 29a. Certifier Medical

2 Accident

3 Suicide

4 ☐ Homicide

State Registrar

VA.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. ature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

KIS MO OME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRECHER, MO OME

524 Hawkes bury La. Silverspring, mo 20904

28f. Location (Street and Number or Rural Route Number, City or Town, State)

31. Date filed (Month, Day, Year)

6 ☐ Could not be

determined

32. Registrar's Signature...

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11.57 AM CORGE 2010 Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MediCAL Ltimure VA Ltimore 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Min. (Month, Day, Year) 10/22/1923 Hours. washington, DC Director 578-24-1950 86 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maruland Anne Arundel Jessup 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20794 U.S.A. 2882 Jessup Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces?
1

Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced WWII White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Wholesaler Liquor injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Paul Pota Routzounis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2882 Jessup Road, Jessup, Maryland 20794 Pamela Pitcher - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite 1 X Burial 2 Cremation 3 X Removal from State 10/05/2010 Arlington, Virginia 4 Donation 5 Other (Specify) Arlington Natl. Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee M01024)o~ 11800 New Hampshire Ave., Silver Spring, ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, un. List only one cause on each line. 23a. Part 1. Enter the dishock, or hear fail Immediate Cause (Final Onset and Death Physician/ Prenunduia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause, Enter Underlying Examine Due to (or as a consequence of) ysician and Cause (Disease or imjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Division of Vital Be B 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျပ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 1275851255 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) i onorth Greens St Baltimure.

Registrar DHMH 17 Flev 7/2008

State

31. Date filed (Month; Day, Year)

68760

Box (

Registrar's Signature

10-07214 Leslie Poe Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 30577
State of Maryland / Department of Health and Mental Hygiene

		1- For State Critificate Registrar		Reg. N	lo.	
Physici	an/	Decedent's Name (First, Middle,Last)		2. Date of Death	v Year	3. Time of Death
/ledical Exami	ner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	September 19	9, 2010 4c. County of Death	0400 hrs
		Washington Adventist Hospital	Takoma Park	"	Montgomery	
Funeral Director		5. Social Security Number 266-49-6283 6. Sex 7. Age (In yrs. last birthday 1 2 F	y) If Under 1 Year If Under 24Hrs Months Days Hours Mir		1962 Gol	hplace (State or ⁿ Washington _{In(ry)} DC
à		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
Varyland 28a-f show any 1.at.once.	tor	Maryland Prince George's	Brentwood			1 Yes 2 XX No
nd 2 hould be filed within 72 hours after death with the Maryland ealth and Mental Hygene. tem 27 is marked other than "natural", or items 23a or 28a-f sho renumatic event, the Medical Examiner must be notified at once.	Il Director	10e. Street and Number 4526 38th Street	10f. Zip Code 20722		U.S.A.	
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21215-0C uld be filed wi Mental Hygien marked other c event, the M		17. Father's Name (First, Middle, Last) Wilford Rabon Poe		e (First, Middle, Maide	,	
212 ald be Mental marke	o Be		ailing Address (Street and Number or	Anne Redmo		Zip Code)
MD and 2 should hand 3 is a sumatic		1 7 7 7 7	Town Square Burns			
re, rault and Frealt fitem		20a. Method of Disposition 1 8urial 2 X Cremation 3 Removal from State 20b. Place of Dis	sposition (Name of cemetery, or other place)	Date 20	c. Location - City or 1	Town, State
Pages nent of		4 Donation 5 Other Specify: Ft. Line	coln Crematory 9/2	23/2010 B	rentwood,	Maryland
Baltimore, MD 21215-C permit. Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If item 27 is marked oth injury or other traumatic event, the		21. Signa of Fune II is rvice Licensee	22. Name and Address of Facility Jo 147 Duke of Glouce	hn M. Taylester St.,	lor Funera Annapolis	al Home s. MD 21401
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not ent failure. List only one cause on each line.				Approximate Interval 8etween Onset and
Examiner	İ	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				Death
		Sequentially list conditions, b				
	miner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
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Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been seled in by the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	street, factory, office building, etc.	28f. Location (Street or Town, State)		al Route Number, City
Ospita l hours uneral		4 Homicide 29a. Certifier 1 Certifies Physician. To the best of my knowledge death or	coursed at the time, date and place and	I due to the equec(s)	and manner on state	A
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated.				
E 3 E 2	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Moni	th, Day, Year)
		Panick Rockall, MD	O.C.M.E.	Se	eptember 20, 20)10
#5		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner	111 Penn Street, Baltimore, M	MD 21201		
	ate	31. Date filed (Month, Day, Year) SFP 2 2 7010 32. Registrar's Signature	back			
Regist	ren	DEF 24 (UIV) (known P. 4	per			

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 30578 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 09 Physician/ 2010 01:00 AM Ε. PHILLIPS MARY Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner lisburi Wicomico at Dastal pice Social Security Number If Under 1 Year If Under 244 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral AUG. 30 1 M 2 X F Months Hours Min. 78 MARYLAND 214-32-0785 Director Usual Residence of Decedent 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits notified at Director 28a-f WORCESTER 1 Tes 2 X No MARYLAND BERLIN 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? ms 23a or must be r Funeral 11209 RACETRACK ROAD 21811 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. n "natural", or item ledical Examiner n 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Many Phillips Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 X No Specify: If Yes, Give Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates d Mental Hygiene. marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ PAIIL J. WALKER MILDRED Μ. BUNTING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tr RALPH T. PHILLIPS/HUSBAND RACETRACK ROAD, BERLIN 21811 MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BISHOPVILLE CEMETERY: 9/18/10 BISHOPVILLE, MARYLAND Funeral Service Licens 21. Signature 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the disease, or complications that can shock, or heart failure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Metastatic Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year 1 Yes 9 Unknown ate has been signed by the page 2 should be detached 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? certificate within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only on Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and dies to the neweels) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0

DHMH 17 Rev 7/2009

State Registrar

Name and address of person who co

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mpleted cause of death (Item 23a) (Type, Print)

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30579 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sep 23, 2010 Adrian Reed 02:38 Bernard 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Devlin Manor Nursing Home Allegany Cumberland 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) Months Days Hours 215-20-5310 1926 84 Mar 5, Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Allegany Cumberland 1 □ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 Industrial Blvd. West 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Pres 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 □Yes 2 □ Xo Specify: WWII 3 □ Widowed 4 □ Divorced white 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Carpenter Carpentry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Reed Margaret (Danahey) Reed 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Miller Daughter 3245 Evitts Creek Road Bedford PA 15522 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Memorial Gardens 9/25/2010 MD LaVale 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature-of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

Physician /Medical Examiner

Department of Health Important: If item 27 any Injury or other to once.

Pages 1

Physician

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show

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Director

Funeral

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Completed

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1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.
em 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

/Medical

Examiner sician and burial-trans Physician/Medical the attending ph nse signed I Completed by page director, B ٩ this After th funeral Medical Certification: n 24 hours after death.

Re Funeral Director: A pletely filled in by the fu

law requires that the death certificate be executed

Hospitel or Attending Physician: The

Division of Vital Records, P.O. Box 68760.

1 □Yes 2 □No 9 □Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify 9 ☐ Unknown	ý)	World Buy Tour		
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause	e given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown		
			24a. Was an autopsy performed prior to completion of cause of death? 1 □ Yes 2 □ No 2 □ No 2 □ No		
25. Was case referred to medical		26. Place of Death (C	Check only one)		
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Hursing Home	5 ☐ Residence 6 ☐ Other (Specify)		
27. Manner of Death 1. ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	on (Month, Day, Year) Injury M	Injury at Work? 1 □ Yes 2 □ No	I. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	Physician: To the best of my knowledge, death occurred at the summer: On the basis of examination and/or investigation, in and manner stated.	he time, date and place, and my opinion, death occurred	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)		

29c. License number

D0017505

21501

29d. Date signed (Month, Day, Year)

t. 23, 20110

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

A-JBOLLING MD

32. Register's Signature

922 NULT'I Hay

within 24 hor To the Fune completely fi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPT.17,2010 **Physician** DEWEY WINFORD RICHARDSON 10:15PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MD.HOSP.CENTER CLINTON PRINCE GEORGES If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1**∑** M 2□ F 90 448-03-0793 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD. CHARLES PORT TOBACCO Director 1 Yes 2 XNo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ŏ 20677 8145 VACCHIANO DRIVE U.S.A. 238 Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than "natural", or Item any injury or other traumatic event, the Medical Exercises 2002. 1 QYes 2 □ No 20yrs • 1 □ Yes 2X No Year or Dates: COAST GUARD 1 Never Married Marned Baltimore, Maryland 21215-0036 ģ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Compl Elementary/Secondary (0-12) College (1-4or 5+) RET. SENIOR CHEIF U.S.COAST GUARD 7th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN HENRY RICHARDSON LOU ELLA FORTNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT RICHARDSON-SON 28949 LIVINGSTON DR. MECHANICSVILLE, MD. 2065 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State TRINITY MEM.GARDENS 9-24-10 WALDORF, MD. 21. Signature of Furieral Service Licenses M00479 22) Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examine The law requires that the death certificate be executed Due to (or as a consequence of): physicien a Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient ٩ 1 Yes 2 No 2 ER/Outpatient 3FT DOA ctor: After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) (ENTER WHURF, LLC. ZOLOZ OLD LINE 32. Registra 's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Ernest Richard Rider September 20,2010 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Washington *Hagerstown* 20623 Emerald Dr. If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Hours 1 🖳 M 2 🗆 F 80 Yrs Director 212-24-7477 Feb 1930 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Hagerstown Md. Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 21742 Funeral 20623 Emerald Dr. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No
If Yes, Give 51-53
Year or Dates. 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: should be filed within 72 hours aft and Mental Hygiene. 'is marked other than "natural", 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Refrigeration Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edna F. Gearhart မ Grant Rider other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 shent of Health a 20623 Emerald Dr. Hagerstown,Md. 21742 Sylvia L. Rider (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State Sept. 24, Smithsburg, Md. Smithsburg Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Jalle MO1414 21783 Smithsburg, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ementi ears Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** vears pertensio Sequentially list condition Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last is certificate has been signed by the attending physician director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months? Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No ☐ Yes After this certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ within 24 hours after death.

To the Funeral Director; After thi completed filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 X Natural 5 Pending Investigation ☐ Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State Registrar

Medical

29a. Certifier

only one)

29b. Signature and title of certifie

30. Name and address of person

ate

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Ma	arylan					/lental Hy		1010	20	E02
			1 - State Registrar AMEND#8perFH,		MbCcb_	C	ertificate d	of Dea	ath ———		Reg. No	2010		582
	Physicia		1. Decedent's Name (First, Middle, La Maria del Rocio I		vera					2. Date of De Month SEP	eath 12 Da	y Year 2010		e of Death
	/Medic Examin		4a. Facility Name (If not institution, giv		IVELG		4b. City, Tow	n, or Loca	ation of Death			. County of Dea		
1	Examili	e	605 S. Frederick	Ave.			Ga	ither	sburg			ontgomer	У	
	Funeral Director		5. Social Security Number unk 6. S	Sex 7. Age	e (In yrs. 22	last birthd Yrs	Months Da		Jnder 24 Hrs. Durs Min.	8. Date of Bi (Month, Di AUG 2	24 ear)	9. Bir 988 Mex	thplace (Sta ountry) LICO	ate or Foreign
	pu »	1	Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or	Location						10d, Insid	e City Limits
	faryla f shor	ō	Maryland Montgom	erv		thers								Yes 2X No
	the N	Directo	10e. Street and Number										ountry?	
	3a or	פֿ	605 S. Frederick	Ave				2087	7			Mexico		
	death	Funeral	11. Marital Status	12. Was Decedent B	Ever in U.	S. 1	Was Decedent If Yes, specify (pecify Yes or No	0-	14. Race - Ame Black, Whit		n,
00	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It to Medical Evanir or must be rediffied at once.	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 ☑N If Yes, Give Year or Dates:	No.		1 X Yes 2□		ecify: Mex:				hite	
3	tural	ed	15. Decedent's E			16a. De	ecedent's Usual O	ccupation			16b. K	(ind of Business	/Industry	
2	hin 72 9. 3m "na Media	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5	+)	(G lif	ive kind of work do e. DO NOT use re	one during stired)	g most of work	king	Mon	tgomery		
7	d with	Som		2	.,	Stud	ent					lege_		
	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)				e (First, Middle		n Surname)				
2	2 should be and Mental is marked raumatic ev	ျှ	Rafael Trujillo			1401.14	-75			Rivera		St. T. Code		
<u> </u>	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship				ailing Address (St.							,
D	Health Health tem 27 other to		Sandra Trujillo/S 20a. Method of Disposition	ister	20b. F		S.Frede: sposition (Name of crematory or other			Gaitnei Date		ocation - City or	20877 Town, State	
2	Pages 'nent of hant of hant; If ite		1 ☐ Burial 2 【☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		- I		c Crematory or other		9/17/	2010	Gle1	n Burnie	e, MD	
	permit. I Departm Importa any Inju		21. Signature of Fuheral Service Vice	-	12202		Thibadea 7 Park	_		_				
۵	permi Depa Impo any Ir once		July / Mile	MC	0056	·	7 Park	Ave.,	Gaith	ersburg	ξ,'M	D 20877		
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the deat	h. Do not	enter the mode of	dying, su	ich as cardiac	or respiratory	arrest,		Approxi Intervat Onset a	imate Between and Death
F	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Acute	Lyn	phob	lastic L	euken	nia					
<i>'</i> .	/Medical Examiner		Toolsing in doubly	Due to (or as	a conseq	uence of):								
	-	Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseq	uence of):								
	nd nd	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C										
Š.	cate be even its ohysician and the burial-transit	EX	resulting in death) Last	Due to (or as	a conseq	uence of):								
0	physicate by the p	dical		▲ d										
אר אמ	leath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome	of pregna	ancy						23d. Date of de	elivery	
<u> </u>	death e atter d for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐ Live birth 4 ☐ Pregnant a			3 ☐ Ectopic pregi 5 ☐ Other (specif					Month	Day	Year
)	at the by the tache	hys	9 Unknown	9 Ll Unknown										
ń	w requires that the de been signed by the should be detached	by F	Part II. Other significant conditions	contributing to death b	ut not res	ulting in th	e underlying caus	e given in	Part I.			use contribute t		of death?
cords,	requir	Completed								1	Yes 2	K		-
ָבָ בי	elaw hasb	nple								24a. Wa:	s an opsy formed?			ngs available of cause of
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5	sicia s certii irecto	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2□	I ED/Outpo	atient 3 DOA	0.11		th (Check only		6 ☐Other (Sp	acifu)	
5	ding Physician: The lav h. Affer this certificate has funeral director, page 2 [,]	다: 1	27. Manner of Death	28a. Date of Inju	iry	28b. Tim Inju		Injury at Work?	т <u> Пинянія гі</u>	28d. Describe			BCITY)	
5	ath. rr; Aft	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	n	y, rear	"","	M	1 ☐ Yes	2 □ No					
2	To the Hospital or Attending Physician: The law requires that the death certificate be executed that 42 hours after death. Within 24 hours after death. To the Funeral Director, fater this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans	Certification;	3 Suicide 6 Could not b 4 Homicide determined		ury - At he c. <i>(Specii</i>	ome, farm fy)	, street, factory, off	ice		28f. Location City or To		and Number or F te)	Rural Route	Number,
	pital ours a ours a leral D		29a. Certifier 1 X Certifying P	hysiclan: To the best	of my kno	owledge, d	leath occurred at t	he time. c	ate and place	e, and due to th	e causei	(s) and manner	as stated.	
1	To the Hospital or within 24 hours afte To the Funeral Discompletely filled in	Medical	(Check only 2 Medical Exa	miner: On the basis o and manner sta	f examina	ation and/o	or investigation, in	my opinio	on, death occu	rred at the time	e, date a	nd place, and du	e to the cau	use(s)
	vithii VTo th	Me	29b. Signature and title of ertifier	00			29c. Li	cense nur	mber		29d. D	ate signed (Mor	th, Day, Ye	ar)
	5		1 Willand	ll no			MD	1925	5		9	9/13/10		
			30. Name and address of person who				pe, Print)	[.] T.J.	achina	on DC	200	10		

31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death YNOLDS Physician/ 8:30AM G 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince Georges Silver Spring Renaissance Gardens at Riderwood 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Social Security Number 6. Sex **Funeral** 1 □ M 2 🕱 F Min. Hours Director 79 146-28-6674 July 14.1931 New York Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2x X No MD Montgomery Silver Spring 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 3152 Gracefield Road, MS522 20904 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home other traumatic event. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. and Mental F ည William J. Grady Mary L. Lucey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia R. Johnson / daughter 7001 East Avenue. Chevy Chase, MD 20815 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) September ☐ Burial 2XXCremation 3 ☐ Removal from State Alexandria, VA 13, 2010 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

rancis J. Collins Funeral Home, Inc.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility rancis J. Collins Funeral Home, Inc. 500 University Rlvd. West, Silver Spring, MD 20001 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition **Medical** resulting in death) _xaminer Sequentially list conditions, if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed as the death.

Director After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 Hospital Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work 5 Pending 2 🗌 No 2 Accident
3 Suicide 1 Tes Investigation within 24 hours a er death

To the Funeral Director

completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

. Date filed (Month, Day,

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Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUGUST Physician/ 30,<u>2010</u> 7:15A M JULIA ROBINSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomerv Cente 1ver Spring Chase Nursing Rehab If Under 1 Year If Under 24 H Months Days Hours Mi 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏝 F Min. Months (Month, Day, Year) 126/1924 Como NC **Director** 86 227-26-6168 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland Director Yes 2 No <u>Fort Washington</u> <u>Prince George</u> 10e. Street and Number 10g. Citizen of What Country? Funeral USA 10850 Indian Head Highway #320 20744 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black If Yes, Give 3 Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Private Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Neddie Vincent Quill Vinson permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Hogart ST. Franklin, VA 23851 Dennis Dinson /nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pi 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Millneck Bap. Cem. 9/4/2010 Como, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Elvin Vaughan Funeral Home 21. Signature of Funeral Service Licensee Mary E. Hedgman South ST. Franklin, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death WK Immediate Cause (Final Physician Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician and mipleted filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably AN Unknown Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🔀 No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🖾 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Signatur 20th D28656 September 7,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

SEP 1

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32. Registrar's Signature

Passi, MD 15245 Shady Grove Rd, #130 Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Day, 2010 Physician/ 0511 Gosie L. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Hospital Rockville If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8 Date of Birth 6. Sex 1 🗚 м 2 □ F 7. Age (In vrs. last birthday) **Funeral** Nov. 10, Months Days Hours Year 1936 CATabama Yrs 73 Director 420-48-9655 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 275 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Rockville Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 United States 10616 Tuppence Court 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 X Never Married 2 Married African 5-0036 1 ☐ Yes 2 A No Specify: 3 Widowed 4 Divorced Year or Dates American 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ROW 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Private 12th Truck Driver Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nellie Rea Curry O. C. Rowe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10616 Tuppence Court Rockville, Maryland 19a. Informant's Name/Relationship (Type, Print) 20858 Christy M. Rowe/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 60511 Ĭ8, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Lincoln Cem. Suitland, Maryland ☐ Donation 5 ☐ Other (Specify) nature of Funeral Service Lion 22. Name and Address of Facility Stewart Funeral Home, 21. Si 4001 Benning Road NE 20019 Washington, DC 23a. Part 1. Onter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, of heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final respiratory Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner pneumonia Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Tue to (or as a consequence of) Chronic obstructive Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury and that initiated events Due to (or as a consequence of) resulting in death) Last ttending physician Completed by Physician/Medical Box 68760 use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death been signed by the should be detached 9 I linknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cardionyopath 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director: After this certificate has page 2 autopsy performed? 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) B B examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မြ 2 **7** No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 Natural 5 Pending iniury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check To the within 2 To the F only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Aselee D0052 55 September, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical Centrer Dr. Rockville Maryland 20850 MD 9901 Abebe, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State A 2010 Registrar

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Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician; The law requires that the death certificate be executed To the Hospital or Attenc within 24 hours after death To the Funeral Director: filled in by the

Registrar

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 2 Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 5 en 7ear Donald Edward Smith 1 tember Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days (Month, Day, Y Hours 1 🔀 M 2 🗆 F 215-26-0137 Yrs Director 80 .1930 Ohic Usual Residence of Deceden 28a-f sho 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at Director 1 X Yes 2 □ No Washington Hagerstown Maryland ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral U.S.A. 409 West Howard Street 21740 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1952-1 X Yes 2 \(\subseteq \text{No} \) Black, White, etc. "natural", or à 1 Never Married 2 Married 3altimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify 1956 Specify: White 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Woodworking Cabinet Maker 9 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract o 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lois E. Schneider Claude D. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 West Howard St. Hagerstown, Maryland 21740 (Wife) Rayetta J. Smith 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State cemetery, crematory or other place) September Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2010 21. Signature of Funeral Service Licensee J.L. Davis Funeral Home 22. Name and Address of Facility MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Examin the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Day Month Year Pregnant at time of death 2 No Yes 1 ☐ Yes 2 L 9 ☐ Unknown the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 00 Completed 1 Yes 3 Probably 4 Unknown JONEN been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an iis certificate has director, page 2 a autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? a No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) hin 24 hours after death. the Funeral Director: After thi mpleted filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending Natural 1 Yes 2 No Investigation Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one 29b. Signature a d title d 29c. License number 29d. Date signed (Month, Day, Year) -0/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10275 31. Date filed (Month, 32. Regis ar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician otember 06 11:00 2106 DRATOS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 🕅 M 2 🗆 F 34 02/27/1976 Honduras Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Baltimore Director Md 10g, Citizen of What Country? 10f. Zip-Code 10e, Street and Number items 23a or ner must be r 403 Lakewood Drive 22124 Honduras Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status ral", or iter Examiner 1 Never Married 2X Married Specify: Honduras 1 X Yes 2 No þ Specify: Hispanic 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education ed other than "natu event, the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Labor Construction 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anastasio Suazo Alicia Villalta 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any Injury or other trau Belkis Yamileth Ortez/Wife 403 Lakewood Dr. Baltimore, Md. 22124 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (**) General Cemetery 09/18/10 Honduras 22. Name and Address of Facility John T. Rhines Funeral Home 3005 12th. St. NE Washington D.C. 20017 23a. Parf 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anoxic brain inyan **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Brainhemorrhan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecution co Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2**X** No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Yes 2 No 26. Place of Death (Check only one 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 Yes 2 No

Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Division of Vital Records, P.O. Box 68760, as by te has be after death.

Director: Aff
d in by the fu within 24 hours aft

To the Funeral Dir

completely filled in within 2

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

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Ith and Mental H 27 is marked of traumatic even

r 28a-f st notified a

28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier seprember 06 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287

State Registrar

Medical

31. Date filed (Month-Day, Year,

32 Registrar's Signature barks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September B, 2010 8:30 am Samue1 L. **Beryl** Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's 7744 Mandan Road Greenbelt Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Jan. 5,1934 1 □ M 2 🎛 F Months Days Hours Director 077-30-3184 76 Virgin Islands Usual Residence of Decedent 10a State U.S. 10b. County Virgin item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 □ No St. John Cruz Bay Islands 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral P.O. Box 183 00831 U.S. Virgin Islands Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes, Give 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry
Virgin Islands Board (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) of Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be George Reynold Simmons Ubaldina Henriquetta Francis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eldra Simmons/Sister 7744 Mandan Road, Greenbelt, MD 20770 permit. Page 1 and 2 Department of Healt Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ₺ Removal from State 09/25/2010 St. John, USVI injury Cruz Bay Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee any in 22. Name and Address of Facility McGuire Funeral Service, B 7400 Georgia Ave., N.W. Wash., D.C. 20012 23a. Ran 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Opset and Death
1.5 years Immediate Cause (Final Uterine Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a some queries of) ending physician and or use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No Ectopic pregnancy Pregnant at time of death Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has yes 24 certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific

Completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Sister's
4 Nursing Home 5 Residence 6 X Other (Specify) residence 1 ☐ Yes 2 🛣 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

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31. Date filed (Month; Day, Year)

14

only one)

Theresa Diaz Montes, M.D. 601 N. Caroline St., 8th Floor, Baltimore, MD 21287 2. Registrar's Signature arks

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2

2010

29c. License number

D0061361

29d, Date signed (Month, Day, Year)

September 9, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death , Day 2010 Year Physician/ DENNIS SWEAT SEPT. 1310 P M 14, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES CLINTON SOUTHERN MARYLAND HOSPITAL Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 223-58-6075 1 💢 M 2 🗆 F MARCH 1. 1945 VIRGINIA 65 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director "natural", or items 23a or 28a-f s **CHARLES** 1 X Yes 2 No MD WALDORF 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 3088 HUNTINGTON CIRCLE 20602 UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces 1968 1972 Black, White, etc. 1 Never Married 2 Married 2 No Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Specify BLACK 3 Divorced 4 Divorced Year or Dates e 1 and 2 should be filed within 72 hours t of Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, the Medical I Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) MATERIALS HANDLER FEDERAL GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ MATTHEW LEONDRUS SWEAT ANNIE KING SWEAT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE PRYOR-SWEAT/WIFE 3088 HUNTINGTON CIRCLE, WALDORF, MD timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State <u>÷</u> ፟ permit. Page Department of Important: If any injury or once. ID VETERANS CEMETERY 09/22/2010 CHELTENHAM. MD 4 ☐ Donation 5 ☐ Other (Specify) Sign : Funeral Service Land 2 THORNTON FUNERAL HOME, 3439 LIVINGSTON ROAD, LYDIA C. THORNTON JOHNSON MO0583 INDIAN HEAD, MD 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ molaremonal disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No After this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred ☑ Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo D0055132

State

Registrar

Suite 310

WAShington DC

1328 Southern avenue

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

RICHARD PALMER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 30592 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Lois Marie Smith September 11 2010 16:34 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Ceci1 Union Hospital of Cecil County E1kton 9. Birthplace (State or Foreign Committee field West Virginia 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2**KX Director** 222-28-5901 June 2, 1946 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Modical Examiner must be nutfilled at Director 1 ☐ Yes 2XXXVo Maryland Ceci1 North East 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 207 Champlain Road 21901 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: <u>გ</u> Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker Manufacturing 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မှ John Calvin Smith Mollie Elizabeth Atkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bobby J. Sexton / Son 4617 Baron Road, North East, Maryland 21901 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of important: If it any Injury or o September 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mayerdale Crematory 14, 2010 Newark, Delaware 22. Name and Address of Facility Crouch Funeral Home 21. Signature of uneral Sanic Licensee dul 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) neumona /Medical Due to (as a consequence of): Examiner 6 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events iner Due to (or Physician: The law requires that the death certificate be executed Physician/Medical Exam 0 and the burial-tran resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year been signed by the should be detached 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Thund 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 2 🗌 No 1 ☐ Yes 2 5 1 ☐ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Propatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 | Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIN CHIT HSU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 5 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Scott September 2010 theodore 3e Orge /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner EASTON Memorial Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex .Sex 1⊠M 2□F **Funeral** Hours Months Days 4-90-261 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Exportment Exportment and once. 10a. State 1 Yes 2 No Director Easton tal bot 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21601 U5A Washington St. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No 21215-0036 Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Poultry perator 18. Mother's Name (First, Middle, Maiden Surname, Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Scott. Hedy Sr. Louise George Theodore ပ 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/60/ 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place Easton, Maryland
20c. Location - Otly or Town, State Brenda 20a. Method of Disposition 1 ☐ Burial 2 12 Cremation 3 ☐ Removal from State Mid Shore Cremation! Cambridge, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral Home, P.A. 510 washington St. Cambridge, MD. 21613 Fanelle C. Skny 23a. Part 1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or consequence of): Veav5 sid osis Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 Tyes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Medical Certification: To After this funeral o 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 9/3/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)) 32. Registrar's Signatu 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Ameno#30 Per PHYS PGC9-13-10cm 30594 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ SEPT 2010 2:50 PM JULIA Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S CLINTON BRADFORD OAKS NURSING HOME 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Month, Day, 1 🗆 M 2 💢 SOUTH CAROLINA 1920 **Director** 90 577~36**-**1654 Usual Residence of Decedent ural", or items 23a or 28a-f show | Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 X Yes 2 No PRINCE GEORGE'S WASHINGTON MD10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 20744 6810 NEWLIGHT CT. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status þ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: "natural", BLACK Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha NURSING NURSE should be filed v h and Mental Hyg Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည McADAMS MAUDE **NANCE** or other traumatic MACK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.v</u> permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra. 6810 NEWLIGHT CT., FT. WASHINGTON, MD. 20744 JAY E. SEARLES/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE, MD. CHAMBERS CREMATORY 9-7-2010 21. Signature of Funeral Service Lipensee L HOME & AVE., RI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Onset and Deau Immediate Cause (Final Physician disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury for use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day After this certificate has been signed by the a funeral director, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 sing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of .Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suick Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Number Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif

State Registrar 1 Date filed (Mo

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30595 State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death SEPTEMIER 12:08 PM Physician/ Danina Μ. Savov Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince Georges Cheverly Prince Georges Hospital 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year, Months Hours 1 □ M 2 😾 F Tuly Director 219-96-7974 MD Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County within 72 hours after death with the Maryland Director 1 XYes 2 No Lexington Park MD Saint Mary's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral 20765 2181 Ronald Drive ited States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give ģ Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Completed Black Year or Dates and Mental Hygiene.
is marked other than "naturaumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Cashier Private Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph МсСоу Bell permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic <u>Michelle Savov</u> other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2181 Ronald Drive Michelle Savoy/mother Place of Disposition (Name of cemetery, crematory or other place)

Place of Disposition (Name of cemetery, crematory or other place) Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)

Resurrection Cemetery

9/14/10 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, MD. 20746 23a. Pary 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 1-4-747 disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown been si should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed 1 ☐ Yes 2 🔏 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 X Natural 5 Pending Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certi 29c. License number who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 3001 TSION

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Day Month Year September 2,2010 2:37A Ernest Reed Sawyers 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince Georges Hospital Cheverly Prince Georges If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 1,1939 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Say Months 1**⊋**M 2□F 71 Yrs. NC 239-62-7690 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☑ Yes 2 ☐ No PG Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6205 Hellen Lee Drive United States 20735 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Olivia Smith Joe Henry Sawyers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5202 Larwin Court
Temple Hills, MD. 20748

20b. Place of Disposition (Name of Arthur Sawyers/brother 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 9/10/10 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Riverdale Park Crematory Riverdale, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septicemia disease or condition resulting in death) Due to (or as a consequence of): Methicillin-Resistant Staph Aureus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Monknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 PNo 2 2 No 1 Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

/Medical Examiner The law requires that the death certificate be executed ettending physicien end for use as the burial-transit Division of Vital Records, P.O. Box 68760 signed by the e

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To the Hoepital within 24 hours a To the Funerei C completely filled

Hospital or Attending Physician:

Physician

Physician

/Medical

Examiner

Director

MD

Funeral

Director

item 27 is marked other then "natural", or itema 23a or 28a-f ehow other traumatic event, the Madical Examinar must be notified at

death with the Maryland

72 hours after

d 2 should be filed within 72 in and Mentel Hygiene. 7 is marked other then "na

Pages 1 and 2 si ment of Heelth an ant: if item 27 is r

ö permit. Page Department of Important: if eny injury or

Baltimore, Maryland 21215-0036

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes 2 No

4 Homicide

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 29b. Signature and title of certifier

1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00026024

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.D., 1160 Varnum St., NE, Washington, DC 20018

29c. License number

State Registrar 31. Date filed (Month, Day, Year) SEP 1 3 2010 32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Month September 11:24 PM **Physician** 5,2010 ev /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges t. Washington Medical Center Ft. Washington
If Under 1 Year If Under 28 Hrs. 8 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Hours **Funeral** Months Days 1**X** M 2□ F 195 Washington, DC 9. 227-96-9290 June 51 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show 1 XYes 2 No Alexandria notified Director 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be a once.)SA 22314 1000 Colonial Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: BACK 3altimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) moving Compan movina Laborer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dora Shorts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Colonial Ave Alexandria, VA Viother Dora lodd 1000 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Bethel Cemetery 12010 Alexandria, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility one ene Funeral Home 21. Signature of Funeral Service Licensee E 21 Nels 814 Franklin Street-Alexandria, VA 22314 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atheroscleratic COVONAY **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician attending ph 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 4 Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been signated the Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl autonsy perform Yes 2 2 No 1 TYes 2□ No 1 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes Certification: To After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) within 24 To the F 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific September 6,2010 D46741

State Registrar

11711 LIVINGSTON RD. FORT WASHINGTON MD 20744 MD SACHDEUA 32. Registrar's Signature 31. Date filed (Month, Day, Year) SEP 1 5 2010 backs

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4 Physician/ Smith Marie 0750 M 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Atlantic General Hospital Berlin 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😡 F (Month, Day, Year) 220-07-7264 89 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Ocean City MD Worcester 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 21842 USA 14500 Wight St., #215 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☑ Widowed 4 □ Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Beatrice A. Ceska Harry M. Corame 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2320 Killoran Rd., Timonium, MD 21093 Harry E. Smith / 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Cape Henlopen Cre 9/13/2010 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign tyle of Funeral Se Nice Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Charic Kidey disease 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Records, Pulmonay Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) မ ER/Outpatient 3 DOA 1 Inpatient 2 After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 🗌 Yes 2 🗆 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 00063904 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9733 Healthway Drive, Belin MD 21811 nie

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

D06

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 11:10 PM Kathryn Taylor Medical Smith 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner oastal pice at the LAKE isbur Wicomico Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2X F Virginia 1/30/1930 Director 80 217-28-2896 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland must be notified at Director 28a-f 1 Yes 2X No Somerset Westover 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral P.O. Box Cowgers Trailer Pk.7 21871 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: white Completed 3X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ntal Hygiene. ed other than " event, the Mec Elementary/Seconday (0-12) College (1-4 or 5+) Sales Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of မ George Washington Taylor Elizabeth Mumford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Kathryn Jones (daughter) 2303 Klej Grange Rd., Pocomoke City, MD 21851 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 9/13/2010 Salisbury, MD 21 Signature of Funeral Service Licensee 22. Name and Address of Facility
Holloway Funeral Home,
107 Vine St., Pocomoke Professional Association City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause hine. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician ari disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, it can be exactly to an additional cause. Enter Underlying Examine Dire to for as a nonsequence of burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, Completed 1 ☐ Yes 2 万No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 🔀 Other (Specify) ျှ 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defitying Nystem 1997. The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

BA 5

GREGORIO M. BEL

SEP 1 5 2010

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

LOSO

Registrar's Signat

M.D.: 5302 CHINABERRY DR., SALISBURY, MD Z1801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Year September 13, Julius Caesar Scalise 1:35 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Montgomery Bethesda Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 √ M 2 □ F Months Days Hours Min. oct 1922 577-28-3736 87 Director Yrs Usual Residence of Decedent or 28a-f shov h and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 USA 12513 Rosebud Drive within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ altimore, Maryland 21215-0036 1943-46 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Packaging Engineer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 6 Felix Anthony Scalise Josephine Frances Cataldi permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Scalise/Wife 12513 Rosebud Drive, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery Sept. 20 Silver Spring, Maryland 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service Licenses Francisdyddrosifiiddy Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Later the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of) Examiner Dysphagia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) law requires that the death certificate be executed the attending physician and the for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day 2 No g 🔲 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Congestive Heart Failure, Parkinson's Records, 1 ☐ Yes 2 😾 No. 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed After this certificate I 1 ☐ Yes 2 ☐ No Yes 2 ⋤ No 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital: 2 XNo Other: ၉ 1 Yes 1XX Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending injury **X**Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

ne and address of person who con

Rosemary Iwunze,
31. Date filed (Month, Day, Year)

MD

D 1885DV

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JULIUS

SCALISE

8600 Old Georgetown Road, Bethesda, MD 20814

d cause of death (Item 23a) (T

Registrar's Signature

D65720

September 14, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Salgado Month Day Fermin Murillo 3: 58 PM 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death COASTAL HOSPICE AT THE WICOMICO DALISBU LAKE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 🙀 M 2 🗆 F Days oct.6,1956 Months Hours Director 595-85-8814 53 Nicaragua Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico Salisbury 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 410 East Vine Street 21804 Nicaragua 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc ģ 1 Never Married 2 Married 21215-0036 White If Yes, Give Year or Dates 1⊠Yes 2□No SpecifNicaraguan Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Cruise Ship Be Maryland ^{18.} Mother's Name (First, Middle, Maiden Surname)
Maria de Los Angeles de Murillo 17. Father's Name (First, Middle, Last) Santiago Murillo Leon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21804 410 East Vine Street Salisbury, Maryland Erick Murillo/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Managua, 1 X Burial 2 Cremation 3 X Removal from State Cemetery, crematory or other place)
Cemeterio Central 9/24/2010 4 Donation 5 Other (Specific <u>Nicaraqua</u> Signat r o Funeral Service Lice see PHYMER PADDES RINALDI FUNERAL SERVICE, P.A. en 9241 Columbia Blvd.Silver Spring, Md20910 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ₹nysician/ disease or condition ear Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to intrinduct cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2**X** No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 No Other (Specify) 1 ☐ Yes 2 🗷 No ္ဝ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number D 29505 09-11-2010 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar GREGORIO M. BELLOSO

31. Date filed (Month, Day, Year)

Registrar's Signature

, M.D.: 5302 CHINABERRY DR. SALISBURY, MD 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Marylar	•	tificate of Dea			. No 2010	30602
	Physicia		Decedent's Name (First, Middle, Lass Robert William S					ate of Death lopth Deamber	c ^D 8, 2010	3. Time of Death 6:54 P M
	Medic Examin		4a. Facility Name (if not institution, give Anne Arundel Medi	street and number)		4b. City, Town, or Local			4c. County of Dea	ith
mark of the	Funeral Director			ex 7. Age (In yrs. 79	last birthday) Yrs.	If Under 1 Year If U	Under 24 Hrs. 8. Da ours Min. (M J)	ate of Birth fonth, Day, Ye		rthplace (State or Foreign ountry) W YORK
	at	or	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Loc	eation				10d. Inside City Limits
	Maryk 28a-f	irect	MD Anne Aru	ındel Cr	rofton	Tree Tree		1 ☐ Yes 2 🔀 No		
	with the	Funeral Director	10e. Street and Number 1740 Albermarle	Dr.		10f. Zip Code 21114			g. Citizen of What C JSA	ountry?
0	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	by Fur	11. Marital Status 1 ☐ Never Married 2 🔀 Married	12. Was Decedent Ever in U. Armed Forces? 1 ♣ Yes 2 ☐ No		Vas Decedent of Hispani Yes, specify Cuban, Me		es or No- etc.)	14. Race - Am Black, Whi	
00	ours afte Itural", sal Exar	eted k	3 Widowed 4 Divorced	If Yes, Give Year or Dates. 1957	7-60	Yes 2 No Sp				hite
Maryland 21215-0036	iin 72 ho ie. han "na e Medio	Completed	(Specify only highest gra Elementary/Seconday (0-12)		(Give F	ent's Usual Occupation kind of work done during O NOT use retired)	most of working		b, Kind of Business	,
d 21	led within Hygiene. other tha ent, the N	Be C	17. Father's Name (First, Middle, Last)	4	Intel	Ligence Off:	1CET Mother's Name (First			ral Governmen
ylan	ld be fil Mental Iarked atic ev	욘	William Vincent	Singleton		Isabelle McCarthy				
	1 and 2 should be file of Health and Mental H fitem 27 is marked o r other traumatic eve	í á	19a. Informant's Name/Relationship (T) Anne Marie Singl		10.1	g Address (Street and N Albermarle		e Number, Ci Croftor		lip Code) 114
ore,	ge 1 and nt of Heal : If item ? or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b.	Place of Dispo	sition (Name of natory or other place)	Date	-	c. Location - City o	
Baltimore,	permit. Page 1 Department of Important: If it any injury or o	- 1	4 ☐ Donation 5 ☐ Other (Specif 21. Signature of Funeral Service Licens	y) Sa		eart Cemete: . Name and Address of I			Bowie, M	D
ñ	Dep Imp any	()	1/en/			6512 NW C	rain Hwy.,	, Bowie	e, MD 20	715
	Pnysician	i d D	23a. Roy 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final	olications that caused the dea ne cause on each line.	ath. Do not ente	or the mode of dying, such	cardiac or resp	iratory arrest,		Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	a. Due to (or a la onsec	quence of):	1				
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consec	quence of,.					
	kecuted n and al-transi	Exam	Cause (Disease or linjury that initiated events resulting in death) Last	cDue to (or as a consec	quence of):					
09/	cate be executed physician and s the burial-transi	ledical Examiner		d						
89	certifi nding use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 Live Birth 2 Fe	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of d	elivery Day Year
О. В	that the death ned by the atte e detached for i	Physic	1 Yes 2 No 9 Unknown	9 Unknown						
σ.	requires that the de been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	nderlying cause given in	1 Part I. 2			to the cause of death? Probably 4 Unknown
ರ	e law req s has bee ge 2 shot	Completed						24a, Was an autopsy performe	prior to death?	
E E	sician: The law is certificate has k	Be Co	25. Was case referred to medical examiner?	(1			of Death (Check only		1 L Y	es 2 No
i Ki	iding Physician: Tth. th. After this certifica funeral director, p	ည	27. Manner of Death	28a. Date of injury	ER/Outpatier 28b. Time of	28c. Injury at	Nursing Home 5		ce 6 Other (Spe injury occurred	ecify)
noi	tending death. tor: Afte the fun	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not b		injury	M 1 ☐ Yes			A - u - d Blumban - a - C	weel Pauto Alumbor
Divis	tal or At s after al Direc ed in by		4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		eet, factory, office		City or Town, S		ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Exam	sician: To the best of my know iner: On the basis of examinations se Practioner: To the best of r	on and/or invest	tigation, in my opinion, de	eath occurred at the tir	me, date and p	place, and due to the	cause(s) and manner stated.
	To th within To th comp	_	29b. Signature and title of certifier	Moser	1	29c. License num	376	290	Date signed (Mon	th; Day, Year)
	FINE		30. Name and address of nerson who	completed cause of death (Ite		Cal Hay	K Am	asbe	Les MP	21401
Λ.	Stat Registra		31. Date filed Month, Day, Year)	32. Registrar's Sign	ature	harles	<u> </u>	U		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death September 10, 2010 Physician/ 4:30 Richard Wilcox Sackett, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5005 Acacia Ave. Bethesda Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8, Date of Birth g. Birthplace (State or Foreign **Funeral** Hours April 30, Months Days 1930 New York 356-24-3456 80 **Director** Usual Residence of Decedent 10c City Town or Location 10d Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814 5005 Acacia Ave. USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces? Black White etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates.1951-53 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Communications Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ruth Gildersleeve Porter Walter Morgan Sackett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melodie Carroll Sackett/Spouse 5005 Acacia Ave., Bethesda, MD 20814 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 9/17/2010 Mitchellville, MD Mt. Oak Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD Fart 1. Enter the escase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SYSTEM ATROPHY PARKINSONIAN disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Be Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 L Yes 2 L 9 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Coronary artery disease 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Dementia 24a. Was an autopsy performed 2 4 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Division of Vital Records, P.O. Box 68760 24 hours after death. Funeral Director: A

сопретер within 2 Registrar

State

only one) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAPIRO

gistrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D35336

10810 CONNECTICUT AVE KENSINGTON MD 20895

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No.Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 9, Physician/ 11:42P^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE'S 1204 COX NECK ROAD CHESTER Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 **X**M 2 □ F Months Days Hours Min. MARYLAND Director 66 217-40-6256 1943 Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10a. State items 23a or 28a-f sho ner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No MARYLAND | QUEEN <u>ANNE'S</u> CHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 1204 COX NECK ROAD 21619 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No the Medical Examiner Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. WHITE Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION FOREMAN BRIDGE WORKER other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည ALLEN JAMES SHORES, JR. MARY JANE BROOKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EILEEN SHORES/WIFE 1204 COX NECK ROAD, CHESTER, MARYLAND, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State WHITEMARSH CEMETERY Department of Important: If it any injury or o 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SEPT 2010 TRAPPE, MARYLAND Signature of Funeral pervice Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND, 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Months Sequentially list conditions, Examiner Due to for as a nonsequence of: cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transil resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 2 No been signed by the a should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 2 X No 1 Tes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 2 40 Other: ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) e Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

Signature

Registrar's

900 Bestquite

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 30605 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret I. Suit September 2010 Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 16, 1914 Age (In yrs. last birthday) g. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 F Months Days Hours Min. 212-05-0356 95 Director Maryland Usual Residence of Decedent show 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director Maryland Anne Arundel Annapolis 28a-f 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code è Funeral 23a 305 S. Cherry Grove Avenue 21401 U.S.A. items (Page 1 and 2 should be filed within 72 hours after death unent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14 Race - American Indian. Armed Forces Black, White, etc. δ 1 Never Married 2 Married ☐ Yes 2. YONO Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give White Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administratvie Assistant 12 Phone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Albert B. Suit Edith Howes other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Jerome/niece 305 S. Cherry Grove Avenue Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State St. Mary's Cemetery 4 Donation 5 Other (Specify) 9/18/2010 Annapolis, Maryland Signature of Funer 22. Name and Address of Facility John M. Taylor Funeral Home 00 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ prebrovusc. priorders disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death signed by the a 1 L Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Division of Vital Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital ٥ 1 Yes npatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Ratural injury work? 1 🗌 Yes 5 Pending 2 Accident within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 🗌 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 30. Name and address of per ho completed cause of death (Item 23a) (Type, Print) 15,0 mulo bring Chark-, MW 2/619

State

Registrar

31. Date filed (Month, Day, Year)

SEP 1 3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30606 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Kieu Tuy Truong 2:45 PM September 9, 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Hebrew Home of Greater Washington Rockville Montgomery 9. Birthplace (State or Foreign Country)
China If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, OCT 20, 5. Social Security Number 7. Age (In vrs. last birthday) Days 1 □ M 2 🕱 F Hours 91 1918 217-94-1120 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 21 No Rockville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20852 6111 Montrose Road, #726 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2 🛣 No Specify: Asian 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 0 Home Maker 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Sinh Nhat Truong Ann Kim Diep 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6699 Hanson Lane, Lorton, VA 22079 19a. Informant's Name/Relationship (Type. Print) Anh Bowne / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Fairfax Memorial F.H. 09/12/2010 Fairfax, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sortice Licensee 22. Name and Address of Facility
Fairfax Memorial Funeral Home M00956 9902 Braddock Road, Fairfax, Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. heart Failure Immediate Cause (Final Congestive disease or condition resulting in death) Due to (or se a consequence of): Hypertension Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dun to 6 fire a gone whench of Anemia Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a Was an

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Means injury or other traumatic event, the Means injury or other traumatic event, the Means injury or other traumatic event, the Means injury or other traumatic event, the Means injury or other traumatic event, the Means injury or other traumatic event, the Means injury or other traumatic events.

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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MD

Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Evaniner must be notified at

within 72 hours after death

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

the Hospital or Attending Physiclan:

2

124 hours after death.

Funeral Director: Aftetely filled in by the fur

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Examine The law requires that the death certificate be executed burial-tra attending physician for use as the burial Physician/Medical signed to þ icate has been si page 2 should b Completed certificate this certific al director, Be Certification: To After thi funeral of

IF FEMALE: 23b. Was decedent pregnant

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

2 Accident

3 Suicide

4 Homicide

1 Natural

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2 No 1 □Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated.

5 Pending investigation

6 ☐ Could not be

29c. License number D 69568

29d. Date signed (Month, Day, Year) 09/10/2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1801 E. Jeffesson St, Packville, mp 20852 A. Chilakamarn

Registrar

Medical

31. Date filed (Month, Day, Year)



MD

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene											
	ecil (CO_	State of Maryland / Department of Health and M Certificate of Death										
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980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 ☐ Never Marri 3 🌠 Widowed		If Van Cius		11	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp un, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Ame Black, Whit c <i>ify:</i> BL	
215-0036	72 hour n "natu ledical	Completed	(Spec	15. Decede	nt's Education est grade completed)	- 3	(Give I	lent's Usual Occup kind of work done of O NOT use retired)	during most of worl	king	16b. Kind o	of Business	Industry
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and	be filed ental Hy ced oth c event	To Be	17. Father's Name (F						18. Mother's Nan	ne (First, Middle, OU DANI)		ame)	
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e, K	and 2 s Health em 27 ther tr		SHERRI B 20a. Method of Disp		/ DAUGHTER	20h Pi		ARIAN DRI	VE, ABER	DEEN, M			01 r Town, State
Baltimore,	Page 1 nent of ant: If it				3 ☐ Removal from State Specify)	CE	emetery, cren	natory or other plac	, INC 9,			•	ESTER, PA
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09289	eath certificate be executed attending physician and for use as the burial-transit	edical Examiner	Secule ritary fist co- if any, leading to im- cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	injury	C. Due to (or as d.								
. Box 687	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. 24 hours after death. 15 hours after death. 16 the control of the this certificate has been signed by the attending physici eted filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	nonths?	23c. If yes, outcome 1	2 Fetal	Ideath 3	Ectopic pregnand Other (specify)	ру		23d	. Date of de Month	əlivery Day Year
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Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification of the funeral director, completed filled in by the funeral director.	Medical Certificate:	2	Investi 6 Could detern	not be 280 Place of Ini			M 1 L	Yes 2 ☐ No	28f. Location (3 City or Tov	Street and Nu vn, State)	ımber or Rı	ural Route Number,
	e Hospita 24 hours e Funeral	Medical	(Check 2	Medical I	p Physician: To the best of Examiner: On the basis of Nurse Practioner: To the	examination	and/or invest	tigation, in my opinio	on, death occurred a	at the time, date a	and place, and	d due to the	cause(s) and manner stated.
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U			30. Name and address	ess of person	who completed cause of	leath (Item	23a) (Type, F	Print)	1 1	2	1 /	eno	2/8/1
			31. Date filed (Month	800	7) 3-K	no	69	3 Y G	wigh	LB.	100	_	-1861
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Ma		rtment of Health and N tificate of Death	Mental Hygiene	2010 20602
	Physicia	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month 09 04	3. Time of Death 11:17 p M
-	/Medic		Richard Thomas	ti oli = 1 di (D-di		2010 11:17 p M	
	Examin		4a. Facility Name (If not institution, give street and number) Fort Washington Hospital		4b. City, Town, or Location of Death Fort Washington	Pr	rince Georges
	Funeral		5. Social Security Number 6. Sex 7. Age 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	(In yrs. last birthday) 78 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) March 3,	9. Birthplace (State or Foreign Country) Georgia
	Director		Usual Residence of Decedent	70		march 3, 1	
	yland how		10a. State 10b. County	10c. City, Town or Loc	cation		10d. Inside City Limits 1 AYes 2 □ No
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	vith th	ig	10c. Street and Number		10f. Zip Code 20744		itizen of What Country? SA
	eath v	Funeral Director	12712 Lampton Lane 11. Marital Status 12. Was Decedent E	ver in U.S. 13. V			14. Race - American Indian,
(0	ifter d iner	臣	Armed Forces? 1 □ Never Married 2 □ XMarried 1 □ Yes 2 X N	0	Vas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		☐Yes 2☐MNo Specify:		Specify: Black
5-6	"natu	letec	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupation kind of work done during most of work OO NOT use retired)		Kind of Business/Industry
212	within ene. than	dmc	Elementary/Secondary (0-12) College (1-4or 5-10th	+)	r Operator	Cor	nstruction
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/lar	uld be Menta arked aric ev	To B	Henry Thomas		Ella Mae	Simpson	
, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print) Marlene Thomas/Wife	19b. Mailin	g Address (Street and Number or Ru Lampton Lane Ft.	ral Route Number, City Washingtor	or Town, State, Zip Code) n, Md 20744
Baltimore,	es 1 a of He of item or othe		20a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other place)		Location - City or Town, State
Ë	Pag tment tant:		4 □ Donation 5 □ Other (Specify)	Crestview	Cemetery 9-16 Name and Address of Facility Ma		ro, Georgia
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licensee		Name and Address of Facility 114 308 Suitland Road		MD 20746
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final	e.	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a consequence of):	CHSECHATOWN		
T	Examiner		Cov-o	nam (MTERY MCCO	Ne .	
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9	eath certifica attending ph for use as th	Physician/Medical	IF FEMALE:		FUT		
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ıd	w require s been sig should b	ed b	bremature ventr	remen	sews	1 ☐ Yes	2 No 3 Probably 4 Unknown
ecc	law re nas be	Completed	•			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
E H	ician: The lav certificate has ector, page 2:	Con				performed? 1 □ Yes 24 N	death? lo 1 □ Yes 2 □ No
Vit.	sician certif rector	Be	25. Was case referred to medical examiner? Hospital: Hospital:	0 E 50/0 11 15 1	Other	th (Check only one)	0.70%
of	ding Physician: The In. After this certificate hir funeral director, page	n: To	1 ☐ Yes 2 ☐ No Inpatie 27. Manner of Death 28a. Date of Inju	ry 28b. Time of	1 3 DOA 4 Nursing H	ome 5 Residence 28d. Describe how inju	
ion	Attending death. ctor: Aft	atio	1⊠ Natural 5 Pending (Month, Day 2 Accident investigation	<i>i, Year)</i> Injury	M 1 ☐ Yes 2 ☐ No		
Division of Vital Records,	l or Atte after de Directo	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju	ry - At home, farm, str (Specify)	eet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Check off) (Ch	examination and/or in			
	To the within To the comple	Mec	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
	- >F 0		Nh was		D0033512	9	17/2010
CD	,4		30. Name and address of person who completed cause of d	eath (Item 23a) (Type,	Print) Livingston Rd; Sk	203; FT. W	Astrington, MO 20744
	Sta Registi		31. Date filed (Month, Day, Year) SEP 1 3 2010 Search	Signature Signature	,		1/7/2010 Asttington: Mp 20744

		4	For State Registrar		State of	of Maryla	nd / Depa <i>Cer</i>	artment <i>tificate</i>			and M		giene Reg. N	$2 \Pi I$	0	306	09
			Decedent's Name (Fire	st, Middle,						2. Date of De	ath			3. Time of	Death		
	Physicia Medio		Sheila Urs	uline	Thorpe							Month –	13	^{ay} – 2	ÖÎ'O	4:07	рм
	Examin		4a, Facility Name (if not i			nber)		4b. City, T	own, or	Location o	of Death	-		4c. County of Death			
			3902 Spring			ngdo				_	arfor						
	Funeral Director		5. Social Security Number 580–16–3662		3. Sex 1 □ M 2 🔀 F	7. Age (In yrs. 81	last birthday) Yrs.	If Under	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 03-24-1	th y, Year) 929		9. Birthp Count Trin	lace (State o lry) idad	r Foreign
	F 00 4		Usual Residence of Dece			140.0		-tien							1	0d. Inside Ci	to all limites
	yland f sho	Director		o. County			City, Town or Lo	cation							1		_
	e Mar 7 28a notifi	jr.							Codo				10: 0	1 🔀 Yes 2 □ No			
	th th 3a o	<u>a</u>									1				. Citizen of What Country? ited States		
	ms 2 mus 2 mus	Funeral	3902 Spring	cree		edent Ever in L	IS 13 V				nin? (Sne	cify Yes or No-			- Americ		_
(0	or ite		1 Never Married	2 🗌 Marrie	Armed Fo	orces?		Yes, specif	fy Cubar	n, Mexican	, Puerto i	Rican, etc.)			k, White,		
036	safte ral", Exar	g b	3 X Widowed 4 □	Divorced	If Yes, Giv Year or D	/e	1	☐ Yes 2	₩ No	Specify:				Specify:	Blae	ck	
21215-0036	'natu dical	Completed by			's Education t grade completed)	16a. Deced	lent's Usual	Occupa	ation	t of worki	na	16b.	Kind of Bu	siness Ind	dustry	
21	in 72 ie. han " e Me	E	Elementary/Seconda		College (1		life. D	O NOT use	retired)	0	or worki	'y	ľ		_		
21	d with lygier ther t	Be C					Sale	s Asso	ocia					echt'		npany	
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 2 be notified at other traumatic event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Timothy	Griff	•						er's Name C ist i	e (First, Middle,	Maider 1st		,		
ž	uld b d Mer mark matic								· · ·						total Time (
Ma	2 sho th and ?7 is i		19a. Informant's Name/									l Route Numbe					
ė,	and Heali tem		Judy W. Tho 20a. Method of Dispositi		litchell/		ex 13/6 Place of Dispo			Dr.		<u>er Marl</u> Date		O MD - Location -			
nor	age 1 ant of t: If if		1 🔀 Burial 2 □ C 4 □ Donation 5 □	remation		State	cemetery, crer	natory or oti	her place					entwo	· .		
Baltimore,	artme ortan Injur		21. Signature of Funeral			0.41	rt Linc	. Name and	eme t	s of Facilit	y For	t Linco	11n				
Ba	permit. Page 1 and 2 shu Department of Health an Important: If item 27 is any injury or other trau		1 Lens	RII	hist -	fan.						. Brent					
			23a. Part 1. Enter the d				ath. Do not ente	er the mode	of dying	g, such as	cardiac c	r respiratory ar	rest,			Approximat	
	Physician/		shock, or heart fail Immediate Cause (Final			olon Car	202								1	Interval Bet Onset and I Vear	
	Medical		disease or condition resulting in death)	7	_ a	(or as a conse									+	year	
	Examiner																
	_ +	edical Examiner	if any, leading to immed cause. Enter Underlying	diate	Due to	(or as a conse	quence of):										
	cutec	xan	Cause (Disease or Imjur that initiated events	ry	C. — Duo to	(or on a copen	consequence off.							-			
	cate be executed physician and s the burial-transit	al	resulting in death) Last Due to (or as a consequence of):														
760	physi the t				d												
Box 687	eath certifica attending p	Completed by Physician/M	IF FEMALE: 23b. Was decedent preg	nant	23c. If yes, ou	tcome of <u>pr</u> eg							1	23d. Dat	e of delive	erv	
XO	atter for u	icial	in the past 12 mont	ths?	4 Preg	Birth 2 🗀 Fe gnant at time o		Ectopic p Other (spe		У				Мо		-	Year
Э.	the de	hys	9 Unknown	,	9 🗆 Unk	nown						-			_		
P.O.	v requires that the de been signed by the should be detached	y P	Part II. Other significan	t condition	s contributing to	death but not r	esulting in the u	nderlying c	ause giv	en in Part	I.	23e. Did 1	obacco	use contr	ibute to th	ne cause of d	leath?
ds,	quires an sig uld b	be l										1 🗆	Yes :	2 X No	3 🗌 Pro	bably 4 🗆	Unknown
Ö	w rec is bee	per l										24a. Was		24b. V	Vere auto	psy findings mpletion of c	available ause of
3ec	The la	mo.										perf	ormed?	6	leath?		
a	ician: The law certificate has rector, page 2	Be (25. Was case referred to examiner?	medical					26. Pla	ace of Dea	th (Check	(only one)					
Ξ	hysic his ce I dire	은	1 ☐ Yes 2 🕱 No	0			ER/Outpatie			4 ∟ Ni	ursing Ho	me_5 🗓 Resi	dence	6 🗆 Othe	er (Specify)	
of	ing P	ate:	27. Manner of Death 1 X Natural 5	☐ Pending	28a. Date (Mor	of injury oth, Day, Year)	28b. Time of injury		3c. Injury work	?	- 1	28d. Describe	how inju	ury occurre	ed		
<u>io</u>	tend death tor: A	tific	2 Accident 3 Suicide 6	Investig Could n	et he	of Injury At	hama farm atr	M		Yes 2		006 1	°C4	and Alexandra	ar Pura	Bouta Numl	hor
Division of Vital Records,	or At after of Direction by	Certificate:	4 🗌 Homicide	determi	ned 28e, Place build	e of Injury - At ling, etc. (Spec	home, farm, str ify)	eet, tactory,	, опісе			28f. Location (City or To			er or Hura	Houte Numi	oer,
Ω	spital ours eral l	cal	29a. Certifier 1 🔀	Certifying	Physician: To the I	pest of my kno	wledge, death	occured at t	the time.	date and	place, an	d due to the ca	ause(s)	and manne	er as state	ed.	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 1	Medical Ex	aminer: On the ba	sis of examinat	ion and/or inves	tigation, in n	ny opinio	n, death o	ccurred at	the time, date	and plac	ce, and due	e to the ca	use(s) and ma	anner stated
	To th Withir To th COMP	-	29b. Signature and title			-				number				ate signed			^
			Me	CRO	lerken	~	-> N	V) i	106	95	91			91	15/	2011)
>	5		30. Name and address	of person w								0.00	_	-			
1	,)		Mercedes To				pbell I	Blvd.	Bal	timor	e, M	D 21236	5				
	Sta	te	31. Date filed (Month, D		32.1	Registrar's Sign	valure										

DHMH 17 Rev 7/2009

			State of Maryland / Department			2010	30610	
			Registrar 1. Decedent's Name (First, Middle, Last)	tificate of Death	2, Date of Death	g. NdUIU	3. Time of Death	
	Physicia Medio		Howard Baker Welch		Month a	Pay Year	1330 M	
	Examin	er	4a. Facility Name (if not institution, give street and number) WM Regional Medical Center	4b. City, Town, or Location of De Cumberland	eath	4c. County of Death		
and.	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 I		Allegan	hplace (State or Foreign	
	Director		213-36-4905 1 X м 2 □ F 74 Yrs.	Months Days Hours M	lin. 10/09/1	935 Ke	eyser, WV	
71.17	nd how at	ř	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	cation			10d. Inside City Limits	
	larylar Ba-fs tified	ecto	WV Mineral Keyser				X□ Yes 2 □ No	
Iryland 21215-0036 July be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at matic event, the Medical Examiner must be notified at	the Na or 2	ä	10e. Street and Number	10f. Zip Code	109	g. Citizen of What Co	·	
	th with ms 23 must	Funeral Director	57 Spring Street	26726		USA		
0	er dea or iter niner	y Fu	Armed Forces?	Vas Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White	e, etc.	
Š	ırs afte ıral", I Exan	ed b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	☐ Yes 2 🛚 No Specify:		Specify: Wh	iite	
15-(72 hou "nati	Completed by	(Specify only highest grade completed) (Give I	lent's Usual Occupation kind of work done during most of t	working 16	6b. Kind of Business I	industry	
212	vithin jiene. er thar the N		Elementary/Seconday (0-12) College (1-4 or 5+)	O NOT use retired)	G	arment F	actory	
Maryland 21215-0036	filed valued val	o Be	17. Father's Name (First, Middle, Last) David Gibson Welch		Name (First, Middle, Mai			
<u>ya</u>	uld be I Ment narke natic	욘			h Lee Bak	·		
<u>≅</u>	2 shu har 17 is trau			ng Address (Street and Number or) W. Piedmont				
re,	1 and 2 of Healt item 2		20a. Method of Disposition 20b. Place of Dispo			Oc. Location - City or		
Ē	Page nent ant: I				23/2010	Cresaptown	, MD	
Baltimore,	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	Name and Address of Facility	ral Home,	Inc.	0	
			23a, Part 1, Enter the disease, or complications that caused the death. Do not enter	2.0. Box 912.	Kevser	WV 26726	Approximate	
-4	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	cher disa	200		Interval Between Onset and Death	
	Medical Examiner		resulting in death) a. Due to (or as a consequence of):	1 January Wille	1 1 1			
	<u> </u>	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a poisequence of):	e heart	Low like			
	rted d ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury	nal Paile	Se			
	ate be executed physician and the burial-transit	EX	that initiated events resulting in death) Last C. Due to (or as a consequence of):					
9	that the death certificate be executed ned by the attending physician and detached for use as the burial-transi	edical	d	· · · · · · · · · · · · · · · · · · ·				
200	certific nding I se as	ı√W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	iverv	
POX	v requires that the death certifica been signed by the attending pl should be detached for use as t	Physician/Me	in the past 12 months? 1	Ectopic pregnancy Other (specify)		Month	Day Year	
	at the	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e Did tobac	cco use contribute to	the cause of death?	
ς, J	ires th signe d be d	d by					obably 4, Unknown	
o D	w requ	Completed			24a. Was an	24b. Were aut	opsy findings available completion of cause of	
Ž Ž	The lar ate ha page 2	Som			— autopsy performe 1 ☐ Yes 2 [ed? death?	2 No	
Ta	ician: sertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (C	Check only one)			
<u>></u>	Physical rathing or areal directions	은 .	27. Manner of Death 28a. Date of injury 28b. Time of	ot 3 DOA Other: 4 Nursin	g Home 5 Residence 28d. Describe how		fy)	
o C	nding ath. r: Afte ie fune	icate	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ AccidentInvestigation	work? M 1 ☐ Yes 2 ☐ No	Esal Bossilbo ilon	injury securiou		
Division of Vital Records,	To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,	
בֿ	spital cours at eral D		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of	occured at the time, date and place	e and due to the cause	(s) and manner as sta	ted	
	n 24 h	Medical	(Check 2 Medical Examiner: On the basis of examination and/or invest	igation, in my opinion, death occurr	ed at the time, date and p	place, and due to the c	ause(s) and manner stated.	
_	To the within com		29b. Signature and the of partifier	29c. License number	<i>i</i>	d. Date signed (Month	12-12	
			30. Name and address of person who completed cause of death (Item 23a) (Type, P BASHAR FARTO, 12500 world) (31. Date filed (Month, Day, Year) 32. Registr & Signature	P66600		09/21/	2010	
	_		30. Name and address of person who completed cause of death (Item 23a) (Type, P BASHAR FARTO, 12500 willow	wbrook Rd	, Cunter	-19-0, M	20215 0	
į	Stat	130	31. Date filed (Month, Day, Year) 32. Registry's Signature	bark			10	
	Registra	r	CED 2 9 7010 Denous					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month LaVerne Alice Wallizer 7:16 A. 08 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death **Allegany** LaVa1e 538 A Street 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 XF Months Days Hours Min 85 Yrs **Director** /24/1924 213-22-2658 Pennsylvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notice and once. 10a. State 10b. County 10c. City, Town or Location Director 10d, Inside City Limits 1 Tes 2 X No MD **Allegany** LaVa1e 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 538 A Street 21502 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Celanese Fibers Corp. Secretary Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname, ပ Edith Myers Russell Wineland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21502 Bonnie Fetzer / Daughter 538 A Street, LaVale, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State Cumberland Crematory 09/01/2010 4 Donation 5 Other (Specify) Cumberland, MD 21. Sign were of Funeral Service Licenses 22. Name and Address of Facility Upchurch Funeral Home, P.A. 202 Greene Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Betweer Immediate Cause (Final disease or condition 7HEIMER'S Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Examiner Dise to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnap 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month Year Day signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Yes 2-L eral Director: After this certificate ifilled in by the funeral director, pag 25. Was case referred to ca æ 26. Place of Death (Check only one) examiner? Other: 횬 1 🗌 Yes 1 Inpatient 2 I 4 D Nursing Home ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 🗀 Pending 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after within 24 hours a To the Funeral C completed filled Medical

State Registrar

29a. Certifier

912

31. Date filed (Mo

(Check

only one 29b. Signature and title

30. Name and address of

157

MO

DUVE

who completed cause of death (Item 23a) (Type, Print)

CUMBENIAND MD

Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

21502 JOSE T- LOVERIAJR, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sandra C. Woronow Month September 2010 4:00 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Summerville Assisted Living Potomac Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) New Jersey **Funeral** 1 □ M 2 🗐 Months Days Hours Min. 10/08/1920 Director 89 36-12-0888 Usual Residence of Decedent show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12609 Celtic Court 20850 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. 0 Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: 3 V Widowed 4 □ Divorced oe filed wn...
Mental Hygiene.
'ed other than "natu.
't, the Medical Ey Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Pharmacist Drug Store permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Louis Cohen Rebecca Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12609 Celtic Court, Rockville, Maryland 20850 Dr. Daniel Woronow, son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
King David
Memorial Gardens 1 🙀 Burial 2 🗌 Cremation 3 🔀 Removal from State 4 Donation 5 Other (Specify) 09/14/2010 Falls Church, Virginia 5 native of Fune at Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 20852 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Dementia - End Stage months Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Dause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year 4 ☐ Pregnant9 ☐ Unknown Yes 2 LaNo 9 🗔 Unknown ed by t signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial Fibrillation Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hypertension page 2 performed? certificate 2 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6X Other (Specify) 2 No မ 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director; After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 2 🗌 No

Box 68760 Division of Vital Records, P.O. To the Hospital or Attending Physician; The law requires

work? ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

29c. License number

D28656

29d. Date signed (Month, Day, Year)

September 13, 2010

20850

State Registrar

Medical

only one

29b. Signature and title of certifier

Ravi Passi, MD, 15245 Shady Grove Road, #130, Rockville, Maryland 31. Date filed (Month, Day, Year)

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		1 - State of M. State of M. Registrar		artment of Heal <i>rtificate of Dea</i>			eg. No. 2	10	3061	
Physic /Medi		Decedent's Name (First, Middle, Last) JOYCE DENISE	WELLS			2. Date of Deat Month SEPTEMB	Day	Year 010	3. Time of Death 12:55 P ^M	
Exami		4a. Facility Name (If not institution, give street and number)					4c. County of Death HARFORD			
Funeral Director		217-62-4509 1□ M 2X F	ge (In yrs. last birthday) 56 Yrs.		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, DEC 24	Year) 1953		ace (State or Foreign try) 'LAND	
show	-i	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limit			
the M	Director	MARYLAND HARFORD 10e, Street and Number		ABERDI 10f. Zip Code	EEN	1.1	Oa Citizon of W	hat Count		
with		601 CORNELL STREET, API	108 י	2100	11	'		f What Country? TED STATES		
ING ZIZIS-UU3D be filed within 72 hours after death with the Maryland tial Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Exprising to ust be notified at	Funeral	11. Marital Status 12. Was Decedent Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes ※ 1	Ever in U.S. 13.	Was Decedent of Hispani If Yes, specify Cuban, Me	ic Origin? (Spe exican, Puerto	ecify Yes or No- Rican, etc.)	14. Race	- Americ k, White, e	an Indian,	
Definition (e), Mari yilaring ZIZI3-00350 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Event page.	þ	3 ☐ Widowed 4 X Divorced If Yes, Give Year or Dates:	16a. Dece	dent's Usual Occupation	ecify:		Specify:			
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permit. Pages 1 an Department of Hea Important: If item 2 any injury or other once.		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	R.A. FERR	natory or other place)	C 09/1	13/10	WEST C		,	
permit. Departr Importe any inju		21. Signature of Funeral Service Licensee	Remon 22	Name and Address of F LISA SCOTT 552 LEWIS S	FUNERA TREET	L HOME, HAVRE I	P.A. DE GRACE	E. MD	21078	
Physician /Medical Examiner be executed bulbasician and as the privile-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a consequence of): a consequence of): a consequence of):	bructilize	piln	ionarij	dis	eas	e	
ath cer attendin for use	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon		ry Day Year	
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al or Atte s after des l Director d in by th	Certification:	a Displayed 6 Displayed not be	ury - At home, farm, stre c. (Specify)	eet, factory, office	2	28f. Location (St. City or Town		er or Rura	Route Number,	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: /	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner sta	f examination and/or in	n occurred at the time, da vestigation, in my opinion	ite and place, a	and due to the c	ause(s) and mai ate and place, a	nner as si	ated. the cause(s)	
To tl withi To tl com	Me	29b. Signature and title of certifier.		29c. License numl	66	2	9d Date signed	(Month, I	Day, Year)	
2		30. Name and address of person who completed cause of d	eath (Item 23a) (Type, I	Print)	541	tavre	de 6	om om	(0. M	
Sta Registr		31. Date filed (Month, Day, Year) SFP 1 3 2010	ar's Signature	1				176	2107	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 12, PATIENCE LAURETTA WASHINGTON 2010 8:50 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 407 DEMBYTOWN ROAD **JOPPA** HARFORD 8. Date of Birth (Month, Day, Year) APRIL 27, 1922 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Months Days Hours Min 1 □ M 2 X F 88 219-22-6165 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits MARYLAND HARFORD **JOPPA** 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 407 DEMBYTOWN ROAD 21085 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give ☑ Year or Dates: 1 ☐ Yes 2 🔀 No Specify. Specify: 3 Nidowed 4 Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC 12 PRIVATE HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ALEXANDER DEMBY BLANCH FRANKLIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MYRA SMITH / DAUGHTER 407 DEMBYTOWN ROAD, JOPPA, MARYLAND 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) HOLLY HILL MEMORIAL GRD 9/16/10 MIDDLE RIVER, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 cott 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as consequence of): 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Mnknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No autopsy perform 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 28d. Describe how injury occurred

Physician /Medical Examiner

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within 24 hours at To the Funeral E Hospital

law requires that the death certificate be executed

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Department of Heal Important: If item 2 any injury or other

Physician

/Medical

Examiner

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Physician/Medical

Completed by

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Certification: To

death with the Maryland

filed within 72 hours after

Pages 1 and 2 should be filed to ant of Health and Mental Hygicint: If item 27 Is marked other: other traumatic event,

Maryland 21215-0036

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 KNo 9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

1 X Natural

2 ☐ Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifie

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a MIT

31. Date filed (Month, Day, Year) SEP 1 5 2010

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 03 Physician/ WINGATE 6:05 PM SEPTEMBER 2010 TELLE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 6 Sex 8. Date of Birth **Funeral** g. Birthplace (State or Foreign 1 M 2 X F June 26, Hours 220-32-8264 **Director** Maryland 1931 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 12 should be filed within 72 mounts alth and Mental Hygiene. alth and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f sin arke event, the Medical Examiner must be notified. MD Dorchester Cambridge 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 505 Gay Street 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc Baltimore, Maryland 21215-0036 þ 1 Never Married 2 Married white If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify. Specify. Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) line worker seafood processor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William J. Sedgwick Mary Florence Gay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Raymond S. Wingate Jr. 505 Gay St., Cambridge, MD son item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarva 9/8/10 4 Donation 5 Other (Specify) Delmar, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part VEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ SUBARACHNOID HEMORRHAGE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** BASILAR ANGURYSM ARTERY Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last й Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death signed by the a Id be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ HYPERTENSION Completed 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ပ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 1 Natural 5 Pending 1 Yes Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD SEPTEMBER RES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, S. GREENE STREET MANJUNATH 22 MD 21201 MARKANDAYA MD

State

Registrar

31. Date filed (Month, Day, Year)

SEP 08

32. Pegistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician GWENDOLYN WHITAKER 9/11/2010 7:26 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ST. THOMAS MOORE NURSING HOME HYATTSVILLE PRINCE GEORGES 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Months Days Hours Min. 60 579-68-0220 **Director** 10/8/1949 WASHINGTON, DC Usual Residence of Decedent 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City. Town or Location Director 1√DeYes 2 □ No DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2102 MARYLAND AVE #1 UNITED STATES Funeral 20002 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 Ino 2 Specify. Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7. th and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) 12yrs College (1-4or 5+) COOK AMERICAN UNIVERSITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MILDRED JOSEPHINE BOARDERS ၉ UNKNOWN Department of Health and Important: If item 27 is ma any injury or other traumat once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NICOLE WHITAKER / Daughter 12544 WOODSTOCK DR. EAST UPPER MARLBORO MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation DOther (Specify) LINCOLN MEMORIAL 9/18/2010 SUITLAND MARYLAND 22. Name and Address of Facility JOHN T. RHINES FUNERAL HOME, LLC Signature of Funeral Service Licenses 3005 12th ST. NE WASHINGTON DC 20017 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death ediate Cause (Final **Physician** sease or condition esulting in death) 1-eens /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) P.0. ☐Yes 2♥No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ tare Remail Discesse Renal Diglysis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate funeral director, pag TRONG ENCEPHALONATHY 1 □ Yes 1 ☐ Yes 2 No 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Tes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1. Natural 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division the Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No I Director: d in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Funeral Director of the Funeral Director of the filled in 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated within 2 To the D018-52 SEPTEMBER 14 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) eensbury Rd Hyatbuithe MD 20781 Date filed (Month, Day, 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **201** 12:34 MA SR. 13 WEBB SEPTEMBER EDWARD Physician/ PAUL PRINCE GEORGE'S Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** CHEVERLY PRINCE GEORGE'S HOSPITAL 9. Birthplace (State or Foreign 8. Date of Birth Date of Day, Ye (Month, Day, Ye 24 If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) WASHINGTON, DC Social Security Number Days Months **Funeral** 945 64 577-58-8509 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10b. County 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at HYATTSVILLE 1 Yes 2 □ No the Maryland Director PRINCE GEORGE'S MD 10g. Citizen of What Country? 10f. Zip Code USA 10e. Street and Number 20784 Funeral 4700 COOPER LANE filed within 72 hours after death with Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Black, White, etc. 11. Marital Status Armed Forces? 1 ☑ Yes 2 ☐ No ARMY BLACK 1 Never Married 2 X Married þ Specify: 1 ☐ Yes 2 🔀 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give 3 Widowed 4 Divorced Year or Dates "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical GOVERNMENT College (1-4 or 5+) LETTER CARRIER than Elementary/Seconday (0-12) Hygiene. 12TH 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) WILLIAMS DOROTHY and Mental F ည EUGENE BROWN 19b. Mailing Address *Street and Number of Buttl* Scute Number, Mary L'Andi^{e,} 200784 4700 COOPER LANE HYATTSUT LLEE, MARY L'AND^{e,} 200784 19a. Informant's Name/Relationship (Type, Print) BETTY C. WEBB/WIFE permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CLINTON, MARYLAND 9/18/2010 RESURRECTION CEMETERY J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility Signature of Euneral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final FATAL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami physician and s the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as the yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery IF FEMALE: Year 3 Ectopic pregnancy 23b. Was decedent pregnant Month Day in the past 12 months? 5 Other (specify) Pregnant at time of death page 2 should be detached for g Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown <u>۾</u> 24b. Were autopsy findings available prior to completion of cause of death? Completed peen s 24a. Was an autopsy performed? Yes 2 No has 2 🛂 No 1 🗌 Yes eral Director: After this certificate I filled in by the funeral director, pade 26. Place of Death (Check only one) 25. Was case referred to medical examiner?

1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 FR/Outpatient 3 I DOA ျှ 28d. Describe how injury occurred 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 5 Pending 1 ☐ Yes 2 ☐ No Natural М Accident Investigation 2 Accident
3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Partifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one)

State

Registrar

DHMH 17 Rev 7/2009

certifier

29b. Signature and title

Date filed (Month, Day, Year)

6 2010

cause of death (Item 23a) (Type 300 / 405 pt 40 c

32. Registrar's Sig

State of Maryland / Department of Health and Mental Hygiene () 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year WASHINGTON **Physician** ANN **BETTY** SEPTEMBER 2:53 P 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S GLADYS SPELLMAN NURSING HOME CHEVERLY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5 Social Security Number **Funeral** Days Hours 1 □ M 2 🕅 F JULY 21 1933 WASHINGTON, DC Director 577-46-9923 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a State rel', or Items 23a or 28a-f ehow Examiner must be notified at 1 XYes 2 ☐ No Director **BLADENSBURG** PRINCE GEORGE'S 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 5206 NEWTON STREET NE # 103 20710 by Funerai Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 ie marked other than "naturel", or Items 23.
Lry or other traumatic event, it a Nedical Examinational. 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ☐ Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify. Specify: BLACK 3 ☐₩idowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT CUSTODIAL 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be oROBERT FRANKLIN WARD ALICE HERBERT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3805 AYNOR DRIVE MITCHELLVILLE, MARYLAND 20721 ROBERT WARD/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 9/18/2010 LAUREL, MARYLAND MD NATIONAL CEMETERY 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) SEPTICEMIA **Physician** /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a nonsequence of): Examine BREAST CANCER requires that the death certificate be executed burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): sicien Records, P.O. Box 68760 Physician/Medicai the ding phy use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Xunknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes certificate 1 ☐ Yes 2 X No Division of Vital 26. Place of Death Check only one Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4♥ Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼No Certification: To s after de... ral Director: After ... by the funeral di 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 XNatural 1 Yes 2 🗆 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 4 Homicide 🛮 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier SEPTEMBER 13, 2010 belle D0026024 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1160 VARMUN STREET N.E. WASHINGTON, DC 20018 LESTER MILES M.D. 31. Date filed (Month, Day, Year) SEP 1 0 2010 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Physician/ 9:20 PM Howard Gregory Wanner 2010 September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's #226 3800 Enfield Chase Court, Bowie 7. Age (In yrs. last birthday) If Under 24 Hrs. 5 Social Security Number If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours (Month, Day, Year, 1 ፟ M 2 ☐ F 95 473-09-5364 September 13, 1914 Hudson, Wisconsir Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10b. County with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Prince George's Bowie 1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20716 3800 Enfield Chase Court, #226 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🛛 No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done (life, DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) US Government / GSA Procurement Analyst Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ge 1 and 2 should be filed at of Health and Mental H If item 27 is marked ot ပ Nellie Catherine Beilfus Oscar David Wanner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1601 San Silvestro Drive, Venice, FL 34285 Ronald J. Wanner / Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) permit. Page 1 Department of Important: If it any injury or o ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/15/2010 Brentwood, Maryland Fort Lincoln Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Postot enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
O Years shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Hypertensive Cardiovascular Disease Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin attending physician and for use as the burial-transit Cause (Disease or iinjury The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery Physician/ 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) signed by the a Yes 2 No 9 Unknown g Unknown Division of Vital Records, P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 2 No 2 X N 1 Yes 26. Place of Death (Check only one, 25. Was case referred to medical Be examiner? Hospital: Other: 2 🔀 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Director: After injury 5 Pending X Natural 1 Yes 2 No Investigation Accident filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Direct Medical

State Registrar

completed

31. Date filed (Month, Day, Year) SEP 1 6 2010

29b. Signature and title of certifier

29a. Certifier

(Check

Kelvin B. Hao, 14999 Health Center Drive, Suite #201, Bowie, MD 20716 32. Registrads Signat

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D50343

29d. Date signed (Month, Day, Year)

9/15/2010

	1	For State Registrar	State of N	Marylan		irtment of F tificate of	lealth and I <i>Death</i>		eg. No.	30620		
Physician		Decedent's Name (First, Middle Margaret Saint		tting	ton= Iai	ma c		2. Date of Dea Month 9/10/201	Day Y	3. Time of Death ear 8:05 A		
/Medical Examiner		a. Facility Name (If not institution Deer's Head St.	, give street and number	er)	con-sa		r Location of Deat		4c. County of	Death		
Funeral Director		. Social Security Number 220-06-5996	6. Sex 7.	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 F			If Under 24 Hrs		Year)	Birthplace (State or Foreign Country)		
al Christon 128a-1 show ncillied at		Usual Residence of Decedent Oa. State 10b. County	+ 0 %	10f. Zip Code					10d. Inside City Limits 1 ☐ Yes 2 No			
	-	MD Worces Oe. Street and Number							10g. Citizen of Wh	at Country?		
036 urs atter death w urs atter death w annuer must		12805 Kings Ct 1. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Decede Armed Force	s? No		21842 Was Decedent of H f Yes, specify Cub		Specify Yes or No- to Rican, etc.)	Black,	American Indian, White, etc. White		
215-0 thin 72 your	bolonia	(Specify only highest Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4	or 5+)	(Give	dent's Usual Occup kind of work done OO NOT use retire	during most of wa	orking	16b. Kind of Busi	ness/Industry		
A da is da da da da da da da da da da da da da	ב	N/A 7. Father's Name (First, Middle, Doug Whittingto					Marilvn	me (First, Middle, Barton	Maiden Sumame)			
Z 2€2 =		19a. Informant's Name/Relations Marilyn James 20a. Method of Disposition	hip (Type, Print)	20b. F	1280	Kings (Ct. Ocean	ural Route Numbe City, M Date				
Baltimore, permit. Pages 1 at Department of Hea Important: if item any injury or othe		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other S 21. Signature of Figure 1 ≠ ny ce	pecify)	916	pe Heni	natory or other pla Lopen Cre 2. Name and Addre	em. 9/10	0/2010 ne Burbag	rankford e Funera	DE 1 Home		
Balt permit. Depart Import any inj	1	23a. Part 1. Enter the disease, or shock, or heart failure. List	2	sed the deat	10)8 Willia	am St. Be	rlin, MD	21811	Approximate Interval Between Onset and Death		
		dicai	dicai Exa	diseas r condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last	b	as a consec	uence of):			cardi		
S, P.O. Box 6 es that the death certifi gned by the attending be detached for use as	ysician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								of delivery h Day Year		
cords, P. w requires that been signed b should be deta		Part II. Other significant condition.	ons contributing to dea	th but not res	sulting in the u	nderlying cause g	iven in Part I.			oute to the cause of death? Probably 4 Unknown		
I Record The law requir cate has been s page 2 should	complet	Seizure	dis or	der				24a. Was autop perfo 1 Yes	mad/ de	ere autopsy findings available ior to completion of cause of arth? Yes 2 No		
on of Vita Jing Physician After this certifit funeral director	n n	25. Was case referred to medical examiner? Yes 2 No										
DIVIS pital or Att ours efter de eral Direct filled in by t		3 Suicide 6 Could determ 4 Homicide 1 Certifyi	ng Physician: To the b	, etc. (Speci	ify) owledge, dea	reet, factory, office	time, date and pla	City or Too	vn, State) cause(s) and mar	r or Rural Route Number,		
Divisit To the Hospital or Attent within 24 hours effer death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael P. Buchness M.D. Deer's Head State Hospital, Salisbury 31. Resistar's Signature 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year)										
1 HE.		30. Name and address of person Michael P. 15	who completed cause	ol death (Ite	m 23a) (Type Deer 5	Print) Head S	tote Hi	espital, i	Salisbu	ry MD		
State Registra	e	31. Date filed (Month, Day, Tear	5 2010 32. Re	jistrar's Sign	ature	barker		,				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 20/ Physician/ RNICE 232 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 M 2 F Hours (Month, Day, Year) 7/30/1920 227-10-8521 90 Country) Virginia Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Anne Arundel Annapolis Maryland 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 23a or 10g, Citizen of What Country? Funeral USA 1010 York Lane 21403 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ō ģ 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give "natural", Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than should be filed within 7 and Mental Hygiene. 7 Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lakie Bell Cox George C. Turman permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any Injury or other traumatic & 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8009 Wolftrap Rd, Dunn Loring, VA 22027 Donald P. Whitworth III - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 9/14/2010 Baltimore, MD Baltimore Crematory 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 102 ATI EU MUNI disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): and I-transit UNIC Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe burial-1 Physician/Medical P.O. Box 68760 anding p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No o Month Dav Pregnant at time of death 1 Yes 2 the a g Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 N 1 Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending s after death.

I Director: Af
d in by the fur 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after
To the Funeral Directory Medical 29a. Certifier 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 | only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registrar's Signature

M un

31. Date filed (Month, Day, Year)

DEFENSE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30622 1 - State Amend 16b per FD, DOR, 9/16/10, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SCPICALOR Dayo 2010 Physician/ 1605 M On Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner at Pastor Eastor Tarbot Hasata Memorial If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day 1 M 2 D F Hours Marylana 216-18-8562 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No veenstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numb Funeral 21658 rrinaton 12. Was Decedent Ever in U.S. Armed Forces?

1 1/2 Yes 2 No 1942
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 Š Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Black 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Lumber Industry than " Elementary/Şeconday (0-12) College (1-4 or 5+) Be Maryland 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) and Mental ဂ arl nKnown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is eon injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🗹 Burial 2 🗌 Cremation 3 🔲 Removal from State Wesley Cemeter John veenstown, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name of Address of Ficility
Henry Funera
510 Washing 21. Signature of Funeral Service Licensee Shina HOME, MD. 21613 ngtowsti 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) D-MADERAL Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy nerformed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Anpatient 2 ER/Outpatient 3 DOA ပ္ funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2160

Registrar

State

31. Date filed (Month, Day, Year) SEP 16 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ WEAVER U122M Year i O Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL ANNAPOLIS If Under 1 8. Date of Birth
(Month, Day, Year)
NOV. 20, 1930 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs Funeral 9. Birthplace (State or Foreign 1 □ M 2 🗷 F Hours MARYLAND **Director** Yrs. 222-16-3158 **79** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MARYLAND QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 145 PENNICK DRIVE UNITED STATES 21666 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 STATE OF MARYLAND CLERK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည EDGAR T. WYATT AGNES O'DONNELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENISE BOOZE/DAUGHTER 131 OLIVE BRANCH ROAD, STEVENSVILLE, MARYLAND 21666 20a. Method of Disposition 20b. Place of Disposition (Name of SEPT 14, 20c. Location - City or Town, State 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State STEVENS VTETPEOF other place)
CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 2010 STEVENSVILLE, MARYLAND 21. Signature of Edner FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused each line. Interval Between Immediate Cause (Final On t and Death Physician/ Λ disease or condition Medical resulting in death) Due to (or as a consequence of): O Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence 2 To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ been signed by the atte should be detached for in the past 12 months? Month Day Year ☐ Pregnant ☐ Unknown Pregnant at time of death Yes 2 100 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the 1 only one) 29b. Sigpature 29 c. License number wher 112016

State Registrar 31. Date filed (Month, Day,

Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30624 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 9 2010 5:47A M Dora Williams Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel 323 Sherman Bouyer Lane Pasadena If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Min. Ju 19th, 24 Year 922 1 □ M 2 🛣 F Priminia 216-32-2877 88 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 X No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral 21122 USA 323 Sherman Bouyer Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Black. 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Anne Arundel I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Medical Center 12th 0 Environmental Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alice P. Green Willie Williams Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a 323 Sherman Bouyer Lane Pasadena, Md. 21122 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Faith Williams (Daughter) 20a. Method of Disposition 20H Plabelof DSbs@os (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens | 9-14-10 Annapolis, Md. 4 Donation 5 Other (Specify) Williame a Rockers Schiff Pacility Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the divease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ BESPIRATO disease or condition resulting in death) Medical Examiner a TCC Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and the burial-transit CAR CMENTI that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical attending p use as IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò ATRIAL FIBRICIATION, Records, 1 Yes 2 No 3 Probably 4 Unknown RTENSION, icate has been siç , page 2 should b Completed 24b. Were autopsy findings available 24a Was an II, TREAST CANCER, prior to completion of cause of death? autopsy performed' OSTEOPOROSIS 2 🗆 No certificate 1 Yes HKUMATO 25 Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 1 ☐ Yes 2 🗷 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 X Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier PEPTEMBER 10, 2010 1447494 7.0. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MONICUS Y. LANGSTON 1010 KOREST PR. ANNADOLIS, MY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 3 2010 Registrar

DHMH 17 Rev 7/2009

68760

Box

P.O.

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September Brian Noel Willson 2010 10:16 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 857 Clubhouse Village View Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** 9. Birthplace (State or Foreign 1 🕅 M 2 □ F Months Days Country) 280-30-2770 87 Director Yrs 30, 1922 United Kinadom Usual Residence of Decedent or 28a-f show notified at 10b. County 10a State within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director Anne Arundel Maryland Annapolis 1 ☐ Yes 2 🙀 No ō 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? "natural", or items 23a o Funeral 857 Clubhouse Village View U.S.A. 21401 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Completed 3XXWidowed 4 ☐ Divorced Specify the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) e 1 and 2 should be filed within 72 I of Health and Mental Hygiene.
If item 27 is marked other than "r or other traumatic event, the Med during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Public Relations Library of Congress Be 17. Father's Name (First, Middle, Last)

Cyril Willson 18. Mother's Name (First, Middle, Majden Surname)
Gwendolyn Phillips ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Brian Willson/son 345 Booneridge Lane Lexington, Kentucky Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State jo permit. Page 1 Department of Important: If if any injury or o ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Baltimore Crematory 9/13/2010 |Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Servins Signature 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on ead Immediate Cause (Final Ph sician/ Onset and Death disease or condition Medical resulting in death) a consequence of **Examiner** Sequentially list conditions, il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury une to for as a consenu attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death Month Day Year the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 20X No Other: မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined building, etc. (Specify) within 24 hours a

To the Funeral D Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29c. License number 2010 e of death (Item 23a) (Type, Print) Name and address of person

Registrar
DHMH 17 Rev 7/2009

State

		For State	State of	f Marylar			of Healt		Mental Hy	/	2010	30626	
		Registrar 1. Decedent's Name (First, Middle	e, Last)		Oei	incate	UI Deal		2. Date of De	Reg. No. ha	. 0 1 0	3. Time of Death	
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Exam	iner	4a. Facility Name (if not institution			wn, or Locat	ion of Death			ounty of Deat				
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Directo		199-22-2112	1	83	Yrs.		Days Hou		May 18	Y 1927		Tisylvania	
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arylan a-f sh fied a	Sct	10a. State 10b. County 10c. City, Town or Location Maryland Prince Georges Laurel								ĺ	10d. Inside City Limits 1 1 Yes 2 □ No		
the Mis or 28	ä	10e. Street and Number 10f. Zip Code								10a Citize	n of What Co		
with the s 23a ust be	Funeral Director	6411 Forest Mill	Lane			20	0707			USA	or rmar oo		
death items nerm			12. Was Deced	dent Ever in U.S		Vas Deceden Yes, specify	nt of Hispanic Cuban, Mex	Origin? (Sp	ecify Yes or No-	14	. Race - Ame		
after after xamil	à		ried 1 XYes	2 No			No Spe		rilouri, etc.,	Sc	Black, White ecify: W	e, etc. Mhite	
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Mary 2 should Ith and N 27 is ma		19a. Informant's Name/Relations			19b. Mailin	g Address (S	treet and Nu	mber or Run	al Route Numbe sville, M	r, City_or To	wn, State, Zip	Code)	
and 2 stealth sm 27 her tra		Carol E. Myers -	Daughter ————					Burton	sville, M	aryland	1 20866		
Order 1 straine traine		20a. Method of Disposition 1		State	Place of Dispos cemetery, crem	atory or othe	er place)	1	Date		tion - City or		
Dall LIMOR Dermit. Page 1 Department of i mportant: If it any injury or o	5	4 Donation 5 Other (S		Atla	antic Cr				7,-2010	Gien i	surmie,	Maryland S	
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		23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that ca	tused the deatl								Approximate Interval Between	
Physician Medica		Immediate Cause (Final disease or condition	_ a	ation P								Onset and Death 12-24 Hours	
Examine	_	resulting in death)		ras a consequ								12-24 Hours	
	ne.	Sequentially list conditions, if any, leading to immediate Upper GI Bleeding Due to (or as a consequence of):											
cuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	C	Ischemic Heart Disease							1 Year		
rate be executed physician and the burial-transit	a E	Due to (or as a consequence of):											
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ath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna irth 2 🗆 Feta		Ectopic pres	anancy			230	d. Date of deli	very	
e death the att	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown		ant at time of d		Other (speci					Month	Day Year	
that the degree by the detached		Part II. Other significant condition	ns contributing to dea	ath but not res	ulting in the ur	nderlying caus	se given in P	art I.	23e. Did to	bacco use	contribute to	the cause of death?	
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aw require as been si 2 should I	Completed	Prostate Cancer							24a. Was a		24b. Were aut	opsy findings available ompletion of cause of	
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sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other:	Death (Check	only one)				
g Physer this eral di	e: To	27. Manner of Death	28a. Date of		28b. Time of		Injury at		me 5 Resid			fy)	
ending sath. or: Afte	licat	1 X Natural 5 Pendin 2 Accident Investig	gation	, Day, Year)	injury		work?	- 1		,,			
or Atter de Directer in by t	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 28e. Place of	f Injury - At ho g, etc. (Specify)		et, factory, of	ffice			on (Street and Number or Rural Route Number, Town, State)			
To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,		29a. Certifier 1 Certifying	Physician: To the bes	st of my knowle	edge, death o	cured at the	time, date ar	nd place, an	d due to the cau	se(s) and m	nanner as stat	ed.	
the Ho nin 24 I the Fu	Medical	(Check 2 Medical E	xaminer: On the basis Nurse Practioner: To	of examination the best of my	and/or investign knowledge, de	gation, in my o	opinion, death	n occurred at	the time, date ar	nd place, and	d due to the ca	ause(s) and manner stated.	
5 × × 5 × 0 × 0 × 0 × 0 × 0 × 0 × 0 × 0		29b. Signaturd and title of certifier	151	inici		cense numbe	er		29d. Date signed (Month, Day, Year) September 3, 2010				
		30. Name and address of person v	- "	of death (Item			057216			septen	ш е т Э, .		
H10+	1	Michael Baako, N					Maryland	20707					
Sta		31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signati	ure								
Regist	rar	2EP 1	3 2010	2	4	had.	1						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 30627 State of Maryland / Department of Health and Mental Hygiene 2 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPT BETTY 2010 **JEAN** WHITE 6:00 P M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ATLANTIC GENERAL HOSPITAL WORCESTER BERLIN Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. MARYLAND 215-26-5761 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits MARYLAND 1 X Yes 2 No WICOMICO WILLARDS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7290 RICHARDSON ST. 21874 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐XNo Specify: 3 N Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **EVANS** DENNIS ANNA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT D. WHITE/SON WINDMERE CT., WILLARDS MARYLAND 21874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Dopation 5 Other (Specify) LEWIS CEMETERY 9/16/10 WILLARDS, MARYLAND Signature 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. shock, or heart failure. List only one cause on each Immediate Cause (Final Onset and Death

Physician Medical Examiner

Physician/

Medical

10a. State

Director

Funeral

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Completed

Be

Examiner

Funeral

Director

or 28a-f show

within 72 hours after death with the Maryland ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than '

any injury or other traumatic event,

g physician and as the bunal-transit page 2 should

Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Medical Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Country of the second	Due to (or as a consequence of):					
Sequentially list conditions, if an , leadin to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as a consequence of):					
resulting in death) Last	Due to (or as a consequence of): d.					
IF FEMALE:						
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of deliven Month D	y Day Year	
Part II. Other significant conditions	contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?	
				2 No 3 Proba		
			24a. Was an autopsy performed?	prior to com death?	y findings available pletion of cause of	
25. Was case referred to medical examiner?		26. Place of Death (Chec	ck only one)			
1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	t 3 DOA Other:	lome 5 Aesidence	6 ☐ Other (Specify)		
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28d. Describe how inju				
3 Suicide 6 Could not 4 Homicide determined		and Number or Rural R te)	oute Number,			
(Check 2 ☐ Mapedical Exan	vsician: To the best of my knowledge, death o niner: On the basis of examination and/or investi rse Practioner: To the best of my knowledge, d	gation, in my opinion, death occurred a	at the time, date and place	ce, and due to the cause	e(s) and manner stated.	
29b. Signature and title of certifier	y Jech	29c. License number 1/1/29 7	29d. C	Date signed (Month, Da	y, Year)	

WINTERPLACE PARKWAY, SALIBURY, MD 21804

State Registrar

CANDY BURNS,

(Item 23a) (Type, Print)

10-06907 Darrell Bernard	l We	stbrook State of	Print in Black Indo	ment of Hea	ith and Mental F	_	ible.	2062		
Physic Medical Exan	ian/ nine	1- For State Amend 200, 200, Perf Registrar Amend 200, 200, Perf 1. Decedent's Name (First, Middle, Last)	1 . 1	proo K	<u>tn</u>	2. Date of Death	Day Year 8, 2010	3 0 6 2 0 3. Time of Death 2224 hrs		
		4a. Facility Name (if not institution, give street Prince George's Hospital			Town, or Location of Deat		4c. County of Death Prince George	's		
Funera Directo		5. Social Security Number 6. Sex 212–13–4210	7. Age (In yrs. last	birthday) If Un Moni	der 1 Year If Under 24Hr hs Days Hours Mir	_	(MM/DD/YYYY) 9. Birtl 1970 Cou	nplace (State or South intry) CO (6) Inq		
ow any		Usual Residence of Decedent 10a. State 10b. County		wn or Location	la caba			10d. Inside City Limits		
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	1 For	10f. Zi	p Code	10g	. Citizen of What Coun			
death with the or items 23a o	Funeral D	11. Marital Status 12. 1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces?		ent of Hispanic Origin? (Sify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,		
s after dea rral", or it	<u>≨</u>	3 Widowed 4 Divorced If Ye	Yes 2 No s, Give Year	1 Yes	No specify:		Specify: Blo	acK		
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mortal Hygiene, item 77 is marked other than "natural", or items 23a or 28a-f sho r traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only his Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of wo	Occupation (Give kind of orking life. DO NOT use returned Tech	work done ired)	6b. Kind of Business/In	,		
21215-0036 Muld be filed within 7 Mental Hygiene, marked other than c event, the Medica	Be	17. Father's Name (First, Middle, Last) HUGN STOSC 19a. Informant ame/Relationship (Type,	Project)	40k Mailton Addin	Mae	(First, Middle, Ma	brook	7,74		
, MD 2 and 2 shoul salth and N em 27 is n raumatic	<u>د</u>	Hugh Stinson /	father 1	7815 Ja		enue; Ft	. Washingt	on, MD		
MOT Pages nent of mnt: 14		1 Burial 2 Cremation 3 R 4 Denation 5 Other Specify: 21. Signature of Fuheral Service Licensee	emoval from State	11011011116	111111111111111111111111111111111111111	118/10 +		land, MD		
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Physician /Medical Examiner		Immediate Cause (Final disease a Gun	shot Wound of Back o (or as a consequence of):	THOLERINE MODE	or dying, such as cardiac c	r respiratory arrest	, snock, or neart	Approximate Interval Between Onset and Death		
	ner	Sequentially list conditions, if any, leading to immediate b	o (or as a consequence of):							
ted 1 msit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o (or as a consequence of):							
O, be execu sician and	edical	UNPENDED AM	ENDED							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9	c. If yes, outcome of pregnand Live birth Pregnant at time of death Unknown	2 Fetal death 5 Other (Spe	3 Ectopic pregna	incy	23d. Date of delivery Month Da	y Year		
P.O. E es that the igned by the	2	Part II. Other significant conditions control	ributing to death but not result	ting in the underlying	g cause given in Part I.	_	cco use contribute to th			
of Vital Records, ing Physician: The law requir Affer this certificate has been sumeral director, page 2 should b	Completed		-			24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of		
lital R sician: T s certifica irector, pr	å	25. Was case referred to medical examiner?	al: 1 Inpatient 2 ✔ ER/		26 Place of Death (Check of Other Nursin	only one)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2 No		
l of ing Ph After t funeral	ion: To	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending	8a. Date of Injury 28b		28c. Injury at Work?	g Home 5 Re 28d. Describe how Subject shot	sidence 6 Other:			
Divisic ttal or Atte ars after dea ral Director	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined Vermined Coperation (Specify) Interstate/Express 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Interstate/Express 28f. Location (Street and Number or Rural Route Number or Town, State) Route 197 at Route 50, Bowie, MD								
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the 1	Medical C	29a. Certifier 1 Certifying Physician: To Check only one) 2 Medical Examiner: On the	o the best of my knowledge, d ne basis of examination and/or manner stated.	leath occurred at the	time, date and place, and	due to the cause(s) and manner as stated			
F \$ F 8	Me	29b. Signature and title of certifier	Julio Stated.	290	O.C.M.E.	10	ed. Date signed <i>(Monti</i> September 9, 2010			
^ <		30. Name and address of person who comple	eted cause of death (Item 23a))						

CR 5

State 31. Date filed (Month, Day, Year)
Registrar SEP 1 4 2010

32. Registrar's Signature

Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

UUME

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 30629 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20^{Year} 7:49 a M Ann Alston Martha Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3006 Frisby Street Baltimore If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X**XF Months (Month, Day, Year) 2-24-1945 212-46-0719 Director Usual Residence of Decedent show 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits with the Maryland Director notified 1 √ Yes 2 □ No 28a-f MD na Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a or ner must be n Funeral 3006 Frisby Street 21218 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. ģ 1 Never Married 2 Married 1 Yes 2X No Specify: Black Specify: XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry UNK Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' 2121 Elementary/Seconday (0-12) College (1-4 or 5+) llth grade Nursing Assistant Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event; i once. Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mary Willie Plummer Charlie Alston 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley H. Redding-<u>3006 Frisby Street Balto, Md 21218</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oaklawn Cemetery 10-2-2010 4 ☐ Donation 5 ☐ Other (Specify) Balto, MD . Signature of Juneral Service Licensee 21202 22. Name and Address of Facility March East F/H MD Baltimore, North 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death EREBROVASCUL Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death, I ast and use as the burial-tran Due to or as a consequence of attending physician for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death sate has been signed by the page 2 should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗆 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Mapner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident Investigation the f 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and ₄itle of c 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

7.49am

2010

SEPTEMBER

gistrar's Signatur

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September ^{Day}, 2010 The 1ma W. 1:00 p M Anderson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Charles 6707 Coati Ct. Waldorf 9. Birthplace (State or Foreign Country) S.C Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Charleston 1 🗆 M 2 🔯 F Months Days Hours Min 9(Manth 1 Day Year) Director 247-56-0192 75 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Charles Maryland Waldorf 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6707 Coati Ct. 20603 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cosmetologist Private 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Waring Pyatt Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6707 Coati Ct. Waldorf, Md. Curtis Waring / Son 20603 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Morris St. Bapt. Ch. 9/15/2010 Charleston, S.C. Signature of Funeral Service Licenses Name and Address of Facility Alexander Strong Pope PA 5538 Mariboro Pike/PForestville, Md. 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Indudying Due to (or as a consequence of) Examir ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician by Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day been signed by the sahould be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? this certificate Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify, မ 1 🗌 Yes 2 😾 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 5 Pending 1 X Natural work Accident
Suicide Investigation 1 Tyes 2 🗌 No filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

completed

within 2 To the F

31. Date filed (Month, Day, Year) Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check

only one)

29b. Signature and title of certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

20646

September 24, 2010

29c. License numbe

D28352

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2 Certificate of Death 2. Date of Death 1. Decede s NameWFirst, Middle, Last) 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4021 Font Hill Drive Ellicott City Howard If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) 1 1 M 2 □ F Months Hours Min. Oklahoma 73 573-46-8671 Director Mar Usual Residence of Decedent 28a-f shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Ellicott City 1 Yes 2 No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 4021 Font Hill Drive 21042 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Black White etc. þ 1 Never Married 2 X Married X Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify: white 3 Widowed 4 Divorced 159-62 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Dept of Defense analyst should be filed with h and Mental Hygien is marked other the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Leo Chambers Austin Pauline DeHart traumatic 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4021 Font Hill Drive Ellicott City, MD 21042 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Thelma E. Austin/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) State and decompactor of the Board 655 W. Baltimore Street ice Licen Wade re of Euneral ROP I /Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Other (specify) Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at work?
1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 2 🗆 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one 29b. Signature 29c. License number

O State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who come

31. Date filed (Month, Day, Year)

leted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month SEPT Physician/ JOHN WESLEY BROOKS JR. 20¹⁰ 1610 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 124 RAZOR STRAP RD NORTH EAST CECIL 8. Date of Birth (Month, Day, Year) 6 1952 Social Security Number If Under 1 Year If Under 24 Hrs. 6, Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Months Days Hours Min. MARYLAND Director 58 <u>220-52-6185</u> Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No CECIL NORTH EAST 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 124 RAZOR STRAP RD 21901 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married ģ 2 🗌 No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give 3 Divorced Completed Year or Dates 973-1979 BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) AMMUNITION INSPECTOR DEPARTMENT OF DEFENSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARION BROOKS JOHN W. BROOKS SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAMELA A. BROOKS/WIFE 124 RAZOR STRAP RD. NORTH EAST, MD 21901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 ò 1 A Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) HARFORD MEM. GARDENS 10-02-2010 ABERDEEN, MD 21. Signature of Funeral Service Lice William C. Brown Community Funeral Home-Harford Philadelphia Blvd. 21001 art 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Opeet and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (o as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examir that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 as the b IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown the 9 Unknown P.O. I à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy perforn certificate 1 Yes 2 No Yes filled in by the funeral director, Be Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) ė: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 5 Pending Certifica 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Secrifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) fearne Smoot, R112789 of manyland 22 S. Oreene 31. Date filed (Month, Day, Year) strar's Signature State Registrar

DHMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760	
dospital or Attending Physician: The law requires that the death certificate be executed	
4 hours after death.	
uneral Director: After this certificate has been signed by the attending physician and	

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		1	For State Registrar	State of Maryla		partment of Hea Certificate of Dea			giene Reg. Ne	2010	30633	
Physi Me	ician edica		1. Decedent's Name (First, Middle, Last	Briscoe				2. Date of Dea		3 2 Year	3. Time of Death	
Exar			4a. Facility Name (if not institution, give: Sinai Hompia		1 timo	4b. City, Town, or Loca		1+4	40	c. County of Deat	h	
Funei Direct				X M 2 \square F 7. Age (In yr	rs. last birthda Yrs	Months Days Ho	Jnder 24 Hrs. ours Min.	8. Date of Birt June	h (Yea <i>r</i>) L3,	9. Bird 1923	thplace (State or Foreign untry) MD	
aryland ia-f show ified at		- 1	Usual Residence of Decedent 10a. State 10b. County MD Balti		10c. City, Town or Location Windsor Mill					-	10d. Inside City Limits Y Yes 2 □ No	
with the M s 23a or 28 ust be not		Funeral Director	10e. Street and Number 22 Rhonda Ct. 10f. Zip Code 21244						10g. C	itizen of What Co USA	ountry?	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		2	1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced			3. Was Decedent of Hispan If Yes, specify Cuban, Mo 1 Yes 2 No SA	exican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify: Bla	e, etc.	
215-0 hin 72 hour ne. than "natur e Medical	1	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Seconday (0-12)	lucation	16a. De	ecedent's Usual Occupation ive kind of work done during e. DO NOT use retired)		ing		Kind of Business		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exami		o l	11th 17. Father's Name (First, Middle, Last) Alexander Br	iscoe	<u>Ma</u>			e (First, Middle, an Johr	Maiden			
Mary d 2 should alth and M 27 is mar or traumat		Ì	19a. Informant's Name/Relationship (Ty James M. Brisc			ailing Address (Street and N Rhonda Ct.					o Code)	
imore, Page 1 and ment of Her tant: If item			20a. Method of Disposition 1 → Burial 2 → Cremation 3 → 4 → Donation 5 → Other (Specify	Removal from State	cemetery, o	sposition (Name of crematory or other place) Ville Vet.	i Oct	Date .5, 20	20c. l L () Cr	ocation - City or	Town, State	
Baltimo permit. Page Department (Important: If any injury or	ouce.		2 Senature of Funeral Service Licens	1. Sem	12/	22. Name and Address of Calvin B. 1412 E. Pr	Scruge eston	s Fune St. Ba	era	l Home	21213	
Priysicia		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Medic Examin	ner	ا و.	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								3 days.	
O be executed sician and burial-transit	- 1	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of):										
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicil completed filled in by the funeral director, page 2 should be detached for use as the bu			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							23d. Date of de Month	livery Day Year	
S, P.O. ires that the signed by Id be detac		ρ	Part II. Other significant conditions co Hypertans 1 Hyperliped		resulting in the	ne underlying cause given ir	n Part I.	23e. Did tobacco use contribute to the cause of dea 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛂 Un				
Record The law requate has been bage 2 shou		Completed	Hyperliped	ma,				24a. Was autor perfo	osy ormed?	prior to	atopsy findings available completion of cause of	
tal cian: Cian: Cian: Sertifica		Be	25. Was case referred to medical examiner?	Hospital:		Othori	of Death (Check					
Physic rthis caraldina		은	1 Yes 2 No	1 Inpatient 2	28b. Tim	atient 3 DOA 4	1	ome 5 Residence 128d. Describe h		6 Other (Spec	cify)	
rision C r Attending er death. rector: Afte by the fune		Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		t home, farm,	M 1 ☐ Yes	2 🗆 No		Street a	nd Number or Ru	ral Route Number,	
Div Hospital or 14 hours aff Funeral Di ted filled in		Medical C	(Check 2 Medical Exami	sician: To the best of my kr	nowledge, dea	ath occured at the time, date	eath occurred a	nd due to the ca	use(s) a	and manner as sta	cause(s) and manner stated.	
To the within 2 To the Compler	.		only one) 3 Certifying Nurs 29b. Signature and title of certifier	SYED A	PR12	ge, death occurred at the time 29c. License num D63	ne, date and place mber 170	ce, and due to th	29d. D	ate signed (Mont.	istated. h, Day, Year) 28, 2010 mne Mn 21.	
			30. Name and address of person who c	ompleted cause of death (Item 23a) (Typ	oe, Print) West Be	brekr	re av	e r	Boulfi	mae mo 21.	
Regi	State istra	-	31. Date filed (Month, Day, Year) SEP 3 0 2010	92. Registrar's Si	anature							
DHMH 17 Rev	7/200)(I			7						·	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30634 Reg. No U Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 25, Sept. 2010 6:15 P M Barnabae Harry Ignatius 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 108 Sanderling Court Anne Arundel <u>Glen Burnie</u> . Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Hours April Day, Year 932 Maryland 78 Director 217-24-5834 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 U.S.A. 108 Sanderling Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Secretain Charles (Charles (Charles)) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) <u>Management</u> of Support Services Western Electric Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marsiglia Angelo Barnabae Fannie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolina Barnabae (Wife) 108 Sanderling Court Glen Burnie, Maryland 21060 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem. Grds. 09/30/2010 | Marriottsville Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, 3204 Mountain Road Pasadena, M P.A. arvland 21122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ estive -ong 1 Cars disease or condition Medical resulting in death) Due to (or as a con-quence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for in the past 12 months? Month Year Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CORONARY ARTERY DISENSE, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has page 2 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director; A

completed filled in by the f ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 201 C 356 30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

RUBINSON RUAD:

KMZ, MO

STEPHEN

Strong PARK, MY

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 11:25 PM **Physician** FLORENCE BRILLES 30 08 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. Levindale Nursing Home <u>Balțimore</u> 9. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 7 Yrs. 220-20-1524 84 Oct 25, 1925 Maryland Director Usual Residence of Decedent 4.2 should be filed within 72 hours after death with the Maryland h and Mental Hyglene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2434 Belvedere AVenue 21215 IISA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. black. Completed by 3 Widowed 4 Divorced ental Hygiene. ced other than "nature c event, the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ teacher/principal education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any linury or other traumatic evone. Florence Johnson Caiphus Mills 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4101 Prior Avenue Baltimore, MD Tonya Martin/granddaughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) state Anatomy Board 655 W. Baltimore Street 21. Signature of Europeal Service Lic 21201 Baltimore, MD 23a. Part1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GNUFSTIVE FAILURE **Physician** HEART /Medical Due to (or as a consequence of): Examiner PULMONARY HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examiner death certificate be executed DIS HASE CHRONIC sician and burial-trans Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. signed by the a ld be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ INSUFFICIENCY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 performed? res 2 No 1 Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2₽ No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient P funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Certification: 1. Natural 5 ☐ Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide LCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08-31-2010 PHYSICIAN D0064533 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W. BELVENERE AVENUE (LEVINISALE) mi BALTIMORE MD BABATUNDE AJANI 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2010 2:20 August Rose M. Bonds /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Salisbury 400 F Trinity Drive 8. Date of Birth (Month, Day, Nov 17, Birthplace (State or Foreign
Country) If Under 1 Year | If Under 24 Hrs. Social Security Number unk 6. Sex 7. Age (In vrs. last birthday) Funeral Days Hours Arkansas Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Exambre must be notified at 1 ☐ Yes 2 ☐ No Director Salisbury MD Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21801 400F Trinity Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married black 1 ☐ Yes 2 ▼ No Specify: Specify ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) atth and Mental Hv 17. Father's Name (First, Middle, Last) Be Luberta Hall ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1225 Myrtle Street Blytheville, AR Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other traces Luberta Conley/sister Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 KOther (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Si manue of Funeral Service Licentes Ren 11d 3. Walde Director 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cear-**Physician** 10 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi Due to (or as a consequence of): attending physician Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate nas been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 3 10 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performer 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Amatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

certificate be executed Box 68760. P.0. Division of Vital Records,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director; After it completely filled in by the funeral

6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

(Check only

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifies

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salisbury Nursing & Rehab. 200 Civic Ave. Salisbury, MD 21804 <u>William HAmil</u>ton Robins

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 AM M 3:10 Shirley M. Barnes September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Feb 15, 1942 1 □ M 2 🔯 F Maryland Director 68 213-40-7655 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 IISA 7615 Caytonia Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Lockheed Martin 12 operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ella Mae Simms Jim Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode) 654 N. Prospect Street Hagerstown, MD 21742 Bruce Barnes/son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 X Other (Specify) in state Sign it of Funeral Se /ice Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 23a, Part Approximate Interval Between Immediate dause (Final 4 days Physician/ pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Completed by Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 No BARNES, SHIRLEY 25. Was case referred to medical examiner? **Division of Vital** сотрыет filled in by the funeral director, Be 26. Place of Death (Check only one) Other: Certificate: To 1 🗌 Yes 2 📉 No 1 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending

State Registrar

Medical

2 Accident
3 Suicide
4 Homicide

29a. Certifier

(Check

only one)

3 🗆

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Investigation 6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amit Kumar Rajvanski Suburban Hospital

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D37891

Bethesda, MD

29c. License number

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number.

29d. Date signed (Month, Day, Year)

Sept 22, 2010

City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 25,27,28a-f per me.g908,10/29/2010dhb

Certificate of Death

Reg. No. 30638 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 09-25-2010 Lillian B. Clegg 0755 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Forest Hill Health & Rehab. Harford Forest Hill 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Hours Min 06 - 17 - Day 934 76 Director 219-28-6735 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Harford Forest Hill 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 105K Sunshine Ct 21050 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Customer Service Forset Hill State Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bessie (Unknown) William Barber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Panowitz (Daughter) 803 Benjamin Rd BelAir, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Bel Air Memorial Gar 109-29-2010 Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition queliacula Medical resulting in death) Due to fr as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate CEPTIFICATION OF PROJECT BY MEDICAL EXHAUST The law requires that the death certificate be executed Cause (Disease or iinjury igned by the attending physician and be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death Unknown Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an **Director:** After this certificate has a in by the funeral director, page 2: autopsy 2 No 1 Yes Hospital or Attending Physician; 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident work? 5 Pending 09/07/2010 6:00 a.M Fe11 Investigation 6 [Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 109 Forest Valley Drive, Forest Hill, MD completed filled in by 4 Homicide determined Nursing Home 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Grant Lying Nurse Presidenter: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) Sellenle 27 2016 932211 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

CIT

32. Re

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trar's Signature

Rolon

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2101

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 28 Year 2010 Physician/ 2:55 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice Baltimore imonium 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) **Funeral** 1 X M 2 🗆 F 212.12.54ta 88 Hours Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10a. State death with the Maryland 10d. Inside City Limits Director Kandallstown Baltimone 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21133 LLSA Flistice 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give "natural", or item edical Examiner m . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 ☑ Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Postal Service 12th grade TRUCK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nonie Harrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Williams Eustice Road Randallstown MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/06/2010 Baltimore, MD Mutus Memorial Park 4 Donation 5 Other (Specify) Vaughor C. Greene Funeral Services 22. Name and Address of Facility Signature of Funeral Service Licensee Road landalstown MD 21133 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Enysician/ disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown CARROLL certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 K 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 🗶 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 💢 Natural 5 Pending Accident investigation 24 hours after deat Funeral Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar OHMH 17 Rev 7/2009

State

JONES,

31. Date filed (Month, Day, Year)

CRNP

SEPTEMBER

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 30640 State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 17:50P M Physician/ OPD Baby Boy Carraquel Medical 4c. County of Death Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOAK ins J 5. Social Security Numb 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Sept 17 Year) 2010 1 X M 2 □ F Maryland infant Yrs Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director X☐ Yes 2☐ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21206 6801 Belair Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc 1 X Never Married 2 Married Completed by ☐ Yes Baltimore, Maryland 21215-0036 hispanic 1 X Yes 2 □ No Specify: unknown If Yes, Give Specify: 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) infant infant infant infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Yoselin Carrasquel Guillermo Barral 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 N. Wolfe Street Baltimore, MD 21287 19a. Informant's Name/Relationship (Type, Print) JOhns Hopkins Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \times Other (Specify) in state Sign tur uneral Service State Anatomy Board 655 W. Baltimore Street Wirector Baltimore MD Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed this certificate 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical examiner?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be Inpatient 2 - ER/Outpatient 3 - DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injury work? Natural 5 Pending Accident Investigation 6 Could not be Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) SEPTEMBEY 17, 2010 29b. Signature and title of certifier

State Registrar Date filed (Month, Day, Year) SEP 3 0 2010

who completed cause of death (Item 23a) (Type, Print)
The JOHOS HOPKINS HOSPITAL LOWNORTH WOLFE Street BALTIMOVE, MAYYLAND 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Charles Craig Seotember 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 9. Birthplace (State or Foreign Country) unk If Under 1 Year | If Under 24 Hrs 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral 1 ₹ M 2 □ F Months Hours Min May 6, 1933 Director 226-36-4943 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2X No MD Prince George's Hyattsville ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 20782 USA 4922 LaSalle Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner ท unk 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. unk Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: black Specify: 3 Divorced 4 Divorced Completed Medical unk Decedent's Education 16a. Decedent's Usual Occupation unk 16b. Kind of Business Industry within Hygiene.
Ther than "n, the Mr. (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) unk and Mental Hygie is marked other traumatic event, Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname, unk permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ance. ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7600 Carroll Avenue Takoma Park, MD WAshington Adventist Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🖺 Other (Specify) in state Signature of Funeral S s^{22. Name} and Address of Facility State Anatomy Board 655 W. Baltimore Street MD 2120 Baltimore, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Que to for as a consequence of attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has the lirector, page 2 s autopsy performed death? 1 Yes 2 No Yes 2 25. Was case referred to medical Division of Vital Hospital or Attending Physician: director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Tes ုင 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) nin 24 hours after death.

the Funeral Director: After thinpleted filled in by the funeral 27. Manner of Death 28c. Injury at work?
1 Yes 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗆 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the F

complete Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 68049 and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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Registrar's Signa

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Takoma

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 30642 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 2010 2:22 P. M Phyllis Crunkilton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Hospice Timonium 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 M 2 X F 1170871945 Mary land 64 Director 212 46 3850 Usual Residence of Decedent is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Harford Aberdeen Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21001 1 Poplar Avenue U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🕱 No If Yes, Give 1 Yes 2 No Specify: Specify: 3 → Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Toll Collector 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ James Langellotto Virginia Wisner permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pasadena, Maryland 21122 7947 E. Shore Road Charles Langellotto / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 09/27/2010 Baltimore, Maryland Bavview Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, Or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) HRONIC DRSTRUCTIVE Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the irector, page 2 s autopsy 1 🗌 Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 5 Pending _ Accident Investigation 3 Suicide
4 Homicide in 24 hour.
the Funeral Directory filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and the of pelson who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 23.2010 Robert J. Dillon ,Sr. September 3:05p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9506 "E" Amberleigh Lane Balto. Nottingham 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 1**X** M 2 □ F Hours New York 1937 Director 216-34-9344 iral", or items 23a or 28a-f show Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Balto. Nottingham Md. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "E" Amberleigh 9506 21236 USA Lane Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc.
White Armed Forces? 1 Never Married 2 Married ş Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Human Resources Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Margaret Dillon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 9506"E" Amberleigh Lane Spouse Nottingham, Md.21236 Patricia Dillon 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Bun'al 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-28-2010 Timonium, Md. Dulaney Valley 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md., 2 1236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): physician and the burial-transit Exami Ra Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy signed by the atter in the past 12 months? 5 Other (specify) Month 2 🗌 No g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\to\) Nursing Home 5 \(\overline{\text{Residence}}\) Residence 6 \(\to\) Other (Specify) 2 NO ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 \(\subseteq \text{Yes} 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending ✓ Natural 2 🗌 No 24 hours after death. Funeral Director: A Accident Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) baltimor mo 21234 4134 BEast Joppa 10 Dr. Ann Morrill 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 30644 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEFTEMOTIC 26 6907 2010 M ARION DIANGELO 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Howard Howard County General Hospital Columbia 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth (Month, Day, Months Country)
Maryland Days Hours Min. 1 X M 2 D F 220-22-7733 83 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Howard Mt. Airy 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16404 Old Frederick Road 21771 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 🔀 No White Specify. 3 Midowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Refrideration Mechanic MD Refrigerator 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Umberto DiAngelo Irene Pilly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Calton Daughter 7216 Forest Avenue; Hanover, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Crest Lawn Mem. Garden 9/30/2010 Marriottsville MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Signature of Funeral Service License Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final

Physician/ Medical Examiner

Physician/

Medical

10a. State

MD

Director

Funeral

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Completed

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Examine

Physician/Medical

Completed by

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Certificate:

Medical

State

29a. Certifier

(Check

only one)

MATTHEW 31. Date filed (Month, Day, Year,

e and title of certifier

Marchay 80

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signature

J. Cfuy bo

Examiner

Funeral

Director

iral", or items 23a or 28a-f shov Examiner must be notified at

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"natural",

Ith and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical.

permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Once.

be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the Innertal director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

disease or condition resulting in death)		menutes	_									
Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	Due to (or as a consequence of): MYOCALBIAL SCUEMIA Due to (or as a consequence of): COLDIANY NATELY MISCASE										
resulting in death) Last	Due to (or as a consequence	e of):										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de: 4 ☐ Pregnant at time of death 9 ☐ Unknown				23d. Date of de Month	elivery Day Year						
Part II. Other significant conditions	contributing to death but not resulting	g in the underlying cause give	n in Part I.			o the cause of death? Probably 4 🔀 Unknow	wn					
				24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of s 2 No						
25. Was case referred to medical examiner?		26. Place of Death (Check only one)										
1 Yes 2 No	Hospital: 1 Inpatient 2 KER/6	Other (Spec	cify)									
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	(Month, Day, Year) on	. Time of injury 28c. Injury work?	es 2 No	Describe how injur	y occurred							
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	T 1000 Diago of Injuny - At home	d Number or Ru	ıral Route Number,									

1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

arkal

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

columbia, MD 21044

14066481

29d. Date signed (Month, Day, Year)

SEPTEMBER

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2010

Registrar HMH 17 Rev 7/2009 CEDAR LANE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 30645 State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 04: 36 AM Edward 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hospita Haltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs, last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Month, Day Ye Months **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. City, Town or Location 10b. County 10d. Inside City Limits Director BaltiHore 1 Yes 2 □ No 123 W 2 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 ☐ Never Married 2 X Married þ 1 ☐ Yes 2 No Specify: d\$ lack 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 10ster Harber Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Stevenson nformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code, Street esalto. Stevenson lother 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State tarrison 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Sur 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between Onget and Death Immediate Cause (Final Physician/ Perotic 50 disease or condition Medical resulting in death) te to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or sela consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by within 24 hours after death.

To the Funeral Director After this certificate has been signe 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗀 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident
☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0043375 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMONE, MIN 21209 MERLYTT 2835 SULTE 203 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#20a-c, 22perFH, G908, 10/18/2010, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2 Month Physician/ 2010 PM^M September Janet Ellis Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec 17, 1 9. Birthplace (State or Foreign Country) Kenya Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🗓 F Dec 58 Director 579-11-5156 Usual Residence of Decedent show 10d. Inside City Limits permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 √ No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20903 UK 9066 Piney Branch Road #101 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc ğ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give black Specify. Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 registered healthcare nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk မ Francis Labrosse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9066 Piney Branch Road #101 Silver Spring, MD20903 Leonard Ellis/spouse 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 4 □ Donation 5 ♥ Other (Specify) in state Gate Of Heaven 10/06/2010 Silver Spring, MD 22. Name and Address of Facility McGuire Funeral Services, Inc. Son livre of Funeral Service Li Romald State Anatomy 7400 Georgia Ave. Washington DC Director Baltimore. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory an ock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death ALTHERZOSCLEROTZ Physician Medical Due to (or as a consequence of): Examiner IN INV STO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 month Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner?
11 Yes 2 No Be 26. Place of Death (Check only one) DOA Certificate: To 1 🗌 Inpatient 2 🗍 ER/Outpatient 3 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident 24 hours after deat Funeral Director: 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred 2 Medical Examiner: On the basis of examination and/or investigation d at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death ccurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I the 29c. License number **576**. 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) မ 10 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Emergency Medicine ASSOC. STe200 Germantown, MD 20874 Don Michael Coleman, II

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Moby 14), 3a() 2() 1

gistrar's Signatur

Please Type or Print in Black indelible ink. Ensure All Copies Are Legible.

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29b. Signature and title of certifier	4.5		29c. License	number	1	29d. Date signed (A	Nonth, Day, Year)		
30. Name and address of person who com	pleted cause of death (Iten	n 23a) (Type, Pr	int)	31295		9/241	//U		
31 Date filed (Month, Day, Year)	2. Registrar's Sign	Kenne	and Ave	Ba17,	more	mo 2	1,206		
State Registrar SEP 3 0 2010	Level & Sigli	gav							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month 0945 AM Otember 252016 Garrison, Sr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ARRE N/A 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours Months Min. 1 XM 2 □ F Days 19,1940 Florida 258-54-7812 Director 70 Feb. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 □Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 822 Riverside Drive 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify \$ Specify: 3 Widowed 4 Divorced White Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0wner Engineering Services permit. Pages 1 and 2 should be file Department of Health and Mental He Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Garrison Geraldine Tolbert ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Garrison (Wife) 822 Riverside Drive Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 09/28/2010 | Baltimore Maryland 21. Signature of Funeral Service Liver eq 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) da /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): by the attending physician and stached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? The certificate Vital 1 □ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ∑Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ō 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending Natural 5 Pending investigation ≥ ☐ Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. R gistrar's Signature 31. Date filed (Month. Day, Year) State Registrar

DHMH 17 Rev 1/2001

Certificate of Death

Hospital:

1 🔲 Inpatient

28a. Date of Injury (Month, Day, Year)

1. Decedent's Name (First, Middle, Last)

Alvin C. Goosman

Physician

/Medical

emea)									
Dept	Newspaper	Newspaper							
18. Mother's Name (F	irst, Middle, Maiden Surname)								
Lillian H	eddrich								
	oute Number, City or Town, State, Z	ïp Code)							
Choice Lane H	R522; Catonsville	. MD 21228							
of Date									
etery 10/1/20	10 Baltimore, N	MD.							
Address of Facility Ster.	ling Ashton Schwa								
Home of Cator	nsville, Inc.								
f dying, such as cardiac or re	e: Catonsville. M	Approximate							
1		Interval Between Onset and Death i							
the Cance	ون	SMONTHS							
	3.72								
	23d. Date of deli	very							
nancy ify)	Month	Day Year							
se given in Part I.	23e. Did tobacco use contribute to	the cause of death?							
	1 ☐ Yes 2 No 3 ☐ Pr	obably 4 Unknown							
	autopsy prior to d	topsy findings available completion of cause of							
	performed? death? 1 ☐ Yes 2 No 1 ☐ Yes	2 No							
26. Place of Death (C	Check only one)								
Other: 4 \sum Nursing Home	5 Residence 6 ☐ Other (Spec	cify)							
Injury at 280 Work?	Describe how injury occurred								
1 ☐ Yes 2 ☐ No									
ffice 28f	Location (Street and Number or Ru	ıral Route Number,							
	City or Town, State)								
the time, date and place, an	d due to the cause(s) and manner as	s stated.							
	at the time, date and place, and due								
icense number	29d. Date signed (Month	h, Day, Year)							
218307	Sept 27	2010							
Baltin	I OVE MID 2	4229							
1									

Division of Vital Records, P.O. Box 68760, this certificate has ral director, page 2 a To the Hospital or Attending Physician: nours after death.

neral Director; After this filled in by the funeral di e Funeral

1∐Yes

27. Manner of Death

Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and Atle

Name and address

au 31. Date filed (Month, Day,

Certification: To

Medical

20 No

5 Pending investigation

6 Could not be

(95Y M

Year)

determined

Registrar DHMH 17 Rev 1/2001 State of Maryland / Department of Health and Mental Hygiene

2. Date of Death Day

September 25, 2010

6:00 A M

8. Date of Birth (Month, Day,

Bcltimore 9. Birthplace (State or Foreign Country) Maryland

Oct.31,

10d. Inside City Limits 1 ☐ Yes 2 K No

10g. Citizen of What Country?

4c. County of Death

Black, White, etc. WHite

14. Race - American Indian.

16b. Kind of Business/Industry

Place of Injury - At home, farm, street, factory, or building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at Medical Examiner: On the basis of examination and/or investigation, in and manner stated.

ause of death (Item)23a) (Type, Print

2 ER/Outpatient 3 DOA

28c

28b. Time of

32. Registrar's Signature

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Jane D. Hamilton pm 201 /Medical Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Keha If Under 1 Year 8. Date of Birth (Month, Day, Year) 02-05-1928 Birthplace (State or Foreign Country)
 WV **Funeral** Hours Months Days 1 □ M 2 🔽 F 82 220-22-3845 Director Usual Residence of Decedent death with the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State show d other than "natural", or items 23a or 28a-f shovevent, the Medical Evanities instituted at 1 ☐ Yes 27 No Director Bel Air Harford 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code USA 21014 410 W. MacPhail Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 👿 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 □Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2X No Specify. Specify: White <u>8</u> 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Horse Racing 12 Cashier marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) :. Pages 1 and 2 should be file tment of Health and Mental H tant; If item 27 is marked oth jury or other traumatic even Be Gerald James Hamilton Grace Agnes Vandergrift 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bel Air, MD 21014 (Niece) 211 Princeton Lane Jayne Kuesler Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Page Department o Important: If a 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09-30-2010 Baltimore, MD Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service I Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner robax Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of): Examine executed entra burial-tra Due to (or as a consequence of): attending physician requires that the death certificate be Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Dav Year 5 ☐ Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records. 2 No 1 Tes 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? /es 2 No 1 ☐ Yes Vital Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To of this 28b. Time of Injury 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Division 1 atural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Havre de Grace

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 23 Month Physician/ M. Hromadnik Isabe1 10:10 am^M 2010 September Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4h. City, Town, or Location of Death Examiner Baltimore County Manor Care Rossville Rosedale If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 D M 2 🔀 F Months 215-30-0398 77 Director December Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Completed by Funeral Director notified 28a-f 1 ☐ Yes ax ☐ No Md. Balto. Nottingham 10f. Zip Code 10g. Citizen of What Country? ò 10e. Street and Number ed other than "natural", or items 23a on event, the Medical Examiner must be 4404 Lobelia Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: White 3 🗆 Widowed 4 🗆 Divorced Year or Dates. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor BG &E Ith and Mental Hygien 27 is marked other the traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Jerome Hromadnik Isabel G. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health a tem 27 i Jerome Hromadnik, III 4404 Lobelia Rd. Nottingham, Md. 21236 Department of Health Important: If item 27 any injury or other the once. altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 9-27-2010 Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) Balto. Md. 22. Name and Address of FacilitySchimunek Funeral Home, Inc. . Signature of Funeral Service Licensea 9705 Belair Road Nottingham, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DEMENTIA Immediate Cause (Final Physician/ disease or condition resulting in death) **↓** Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Year in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death signed by the aid be detached for g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital: Other: 2 1 No 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? 1 ☐ Yes 2 ☐ No Natural 5 Pending ☐ Accident☐ Suicide Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b Signature and title of certifi 00060560

Registrar

DHMH 17 Rev 7/2009

State

26, IRON MILL GARTH, COCKETS VILLE, MD -21030

30. Name and address of purn who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

SEP 3 0 2010

KHETERPAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9/13/2010 Day JACQUELINE HASELRIG 4:24 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S JAYSTONE COURT BOWIE 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F 1/11/1950 Country) Thompkinsville Director 579-66-0927 60 Usual Residence of Decedent should be filed within 72 now....and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f shore—"...event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince Georges Bowie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 408 Jaystone Ct. 20721 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Yes 2 XNo 1 Never Married 2 X Married þ Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u> Administrative Mgmt.Specialist Government</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important. If item 27 is marked of any injury or other traumatic eve ပ Andres Johnson Hill Mary Gertrude Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Haselrig / Spouse 408 Jaystone Ct. Bowie, Md. 20721 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Metropolitan 9/21/2010 4 Donation 5 Other (Specify) Alexandria, Va. Signature of Funeral Service 22. Name and Address of Facility Pope Funeral Homes, P.A. icensee 5538 Marlboro Pike Forestville, Maryland 20747 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Gastric Cancer vrs Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical requires that the death certificate be Box 68760 as the IF FEMALE nse yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🔀 No ò Month Day Year detached the 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law After this certificate has performed? 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 X No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Katural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending (Month, Day, Year) 1 ☐ Yes 2 ☐ No death. Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours after death To the Funeral Director:

State Registrar

only one 29b. Signature

Andrew Tyler Putnam 3800 Resevoir Rd. NW Washington, DC 20015 31. Date filed (Month, Day, Year) 32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

29c. License numbe DC33037

29d. Date signed (Month, Day, Year)

September 13, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 0654 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Thelma Virginia Happel 3.38 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE WASHINGTON MEDICAL CENTER AMME If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕇 F Months Min. 220 18 8787 Hours OT/03/1926 Maryland **Director** Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits Maryland Anne Arundel Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 325 W. Arundel Road 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 5 ģ 1 Never Married 2 Married 1 ☐ Yes 2 A No Specify: "natural", 3 Widowed 4 Divorced Completed White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Salesperson Sears Dept. Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stewart Holsinger Elsie (not available) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Happel / Son 3214 North Point Road Baltimore, Maryland 21222 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 09/28/2010 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Part 1. Enter the disease, and shock, or heart failure. List on lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transi BALLATION Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 2 🗆 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Hospital 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending 2 No 2 Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. of certifier ss of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State

✓ DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30655 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HORNE 28,2010 SEPTEMBER ucous Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BACTIMORE N/A LOCH PAVEN COMMUNIT Y LIVING CENTE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 244 20 8058 84 Months Hours Min. North Carolina Director Usual Residence of Decedent shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits notified at Director 28a-f N/A Maryland Baltimore 1 X Yes 2 ☐ No 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 3440 - 6th Street 21225 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give WW II 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 10th College (1-4 or 5+) Globe Poster Printer Printer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Zuma Belle Carter Lucous Glendon Horne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Frances Horne / Wife 3440 - 6th Street Baltimore, Maryland 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State MD. State Veteran Cent. 10/01/2010 Crownsville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Hwy. Baltimore, Maryland 21225 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. art 1. Enter the disease shock, or heart failure. I Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ OBSTRUCTIVE PULMONARY DISEASE CHRONIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or). Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 attending physician for use as the buria Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Hinknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate has page 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Tes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death

To the Funeral Director: A

completed filled in by the fi 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30272 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCA RAVEN BOULEVARD BAITMORE 3900 S. MILLER 32. Registrar's S State Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

SFP 3.0 2010

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registra Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ (0,50PM 2010 Herman Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MADOR WHEATON Wheaton Montgomery 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 **X** M 2 □ F Months Days Hours Min. South Carolina 578-58-5208 Director 65 Sept Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No MD Montgomery Wheaton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 11901 Georgia Avenue 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ģ ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give black 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) engineering foreman maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Martha Williams Willie Hamm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2206 Alice Avenue #204 Oxen Hill, MD 20745 Tonese Hamm/spouse 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔲 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ♣ Other (Specify) in State 21. Signal of Funeral Service Licensee Rona d S Wade State Anatomy Board 655 W. Baltimore Street Baltimore MD Part 1. Inter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MUDCARDIA Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 2 (N) 1 Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 💢 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Tes 2 🗆 No Accident Investigation Suicide 6 🗌 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined n 24 hours after re Funeral Dire Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie within 24 ho

To the Fune

completed fi 2 🗆 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) type, Print

MERLYN VENURY. MD 980/ GEORI SUITE 227, SILVER SPANG GEORGIA Registrar's Signa State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	State of Maryland	Department of He	ealth and Mental	Hygiene

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		1- For State Registrar		Cert	ificate of	Death		, 5	Reg. No.	201		
Physici		Decedent's Name (First, Midd						2. Date of Month	Death Dav	Year	3. Time of Death	
Medical Exam	iner	EMMANUEL 4a. Facility Name (if not institution	JONES			b. City, Town, o	L coation of Do		nber 16,	2010 County of Deat	0108 hrs	
		5620 Marlboro Pike	on, give street and number /			District Hei		atti	Prince George's			
Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. las	st birthday)	If Under 1 Yes		_				
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5-0036 iled within 7 Hygiene. I other than	ပ	17. Father's Name (First, Middle,	Last)				18.Mother's Na	me (First, Midd			LC Halbt IIII	
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MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. n 27 is marked other than "natural", or itens 23a or 28a-f sho numatte event, the Medical Examiner must be notified at ouce	٢	19a. Informant's Name/Relations			F					ty or Town, State		
and and lealt tran		JOYCE LOVE-EL/M 20a. Method of Disposition				tion (Name of ce		Date Date		ocation - City or	S, MD 20747 Town, State	
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Baltimore, permit. Pages I at Department of He. Important: If ite		4 Donation 5 Other Sp 21. Signature of Funeral Service		Iwas	ningtoi 22. Na	n Nat I	s of Eacility	1 11	0 Su.	itland, Eads St	MD NE	
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Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	complications that caused on each line.	the death. D	o not enter th	e mode of dying	, such as cardia	or respiratory	arrest, sho	ck, or heart	Approximate Interval Between Onset and	
Examiner		Imme to the Cause (Final disease or condition resulting in death)									Death	
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To To Con	Med	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,										
	O.C.M.E. September 16, 201											
	}	30 Name and address of person	who completed cause of de	eath (Item 2	3a)							
		•	nt Medical Examiner		-	, Baltimore,	MD 21201					
St Regist	ate	31. Date filed (Month, Day, Year) SEP 3 0	2010 32 Registrar	s Signatur	year	Ker						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30659 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Frank Jacob ,Jr. September 2010 Medical 6:44P 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Balto. Social Security Number 6. Sex 7. Age (În yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** 8. Date of Birth (Month, Day, Yea 1X□ M 2 □ F Months Days Hours Director 90 216-09-2716 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Md. Balto. 1 Yes 2 No Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral <u>4106 Chardell Rd.</u> Condo 1D 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc 1 Never Married 2 X Married 2 No White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Foreman Aerospace Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Frank Jacob, Sr. Margaret Swanson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Jacob Spouse 4106 Chardell Rd. Condo 1D Nottingham Md. 21236 20b. Place of Disposition (Name of cemetery, crematory or other pla 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview 9-25.2010 Balto. Md. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ -ON disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical ナPAM く Jacob Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year signed by the a d be detached f 2 🔲 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signated by page 2 should b 1 \square Yes 💢 No 3 🗆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Deat 28b. Time of 28c. Injury at work? Certificate: Natural 28d. Describe how injury occurred injury 5 Pending Accident Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my kin. Wide Last of my k (Check only one 29b. Signature and title 29c. License number 29d. Date signerd (Month, Day, Year) who completed cause of death (item 23a) (Type, Print) 31. Date filed (Month, Day, Year) egistrar's Signatu State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30660 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Maryanna Jasinski September 24,2010 2252 Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Harford **Examiner** 4b. City, Town, or Location of Death BelAir Upper Chesapeake 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗱 F Months Days Hours Min December 10,1918 Country) Director 215-01-3805 91 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at anne. 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🗓 No Harford Md. BelAir 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 108 E. Ring Factory Road 21014 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √ No Specify: 3X☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacob Bizon Zofia Turek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. Carolyn Monaghan 108 E. Ring Factory Rd. BelAir, Md. 21014 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 9-29-2010 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Dundalk, Md. 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md.21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner 1/0 Sequentially list conditions if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnan 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months' 1 Yes 2 No Pregnant at time of death Day Year 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying gause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypotipidena 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an • Hospital or Attending Physician: The law 24 hours after death.
• Funeral Director: After this certificate has page 2 autopsy 2 1 No Yes 25. Was case referred to medica Division of Vital funeral director. Be 26. Place of Death (Check only one) examiner? ပ 1 🗌 Yes 2 🗗 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 Tyes 2 🗀 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination almost invasigation, it my opinion, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEP 3 0 2010 32. Registrar's State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death September Physician/ 2010 2:05 PM ROBERT JONES Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** DOCTORS HOSPITAL PRINCE GEORGE'S EANHAM If Under 24 Hrs. 8. Date of Birth Social Security Numbe 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min. 6/24/1936 Washington, DC **Director** 244-50**-**4097 74 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location with the Maryland Director 1 X Yes 2 No Maryland | Prince George's Lanham 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? Funeral 2122 Dupont Ave. 20746 United States permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify. If Yes. Give Specify: Black 3 ₩ Widowed 4 □ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Car Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Robert Wilson Alberta Edmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4328 Cast<u>le Tower Ct. White Plains, Maryland 20695</u> Coy L. Jones / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Nurial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Hope Baptist 9/18/2010 Roxboro, NC Sign of Funeral Service Lic ise 22. Name and Address of Facilit Pope Funeral Homes, P.A. arn-Immors 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CANCER LASIZIC Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner SEVERE 5-quartially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine consequence of) Due to (or as a 4 Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death g Unknown g Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? death? 1 ☐ Yes 2 ☐ No 1 Yes 2 director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 46 Other: ျှ 1 Mpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation □ Accider
 □ Suicide Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Secritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2510 2010 WD 30. Name and address of person son who completed cause of death (Item 23a) (Type, Print) 8118 Good Luck Road

Registrar DHMH 17 Rev 7/2009

State

200

32. Registar's Signature

31. Date filed (Month, Day, Year)

43 100 UM

WV

Lanham,

Maryland 20706

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Day 28 1. Decedent's Name (First, Middle, Last) 020 Month Year PM TOHNSON **Physician** ARTHUR SEPTEMBER 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** DCHRAVEN COMMUNITY LIVING CENTER NA BALTEMONE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 0 2 - 1 0 - 2 2 2 1 9. Birthplace (State or Foreign Country) ${
m FL}$. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 263-14-4618 1**X** M 2□ F 88 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State items 23a or 28a-f show ner must be notified at XXYes 2 No Director NA Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21218 3900 Loch Raven Blvd. Funeral filed within 72 hours after death 14. Race - American Indian Black, White, etc. African 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∑Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 "natural", or Specify: American ģ 3 ☐ Widowed 4 🖾 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Boston Metal Steel Worker NA 12th Grade Pages 1 and 2 should be filed inent of Health and Mental Hygint; If Item 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anderson Lucile Johnson Arthur or other traumatic ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,{
m MD}\,$. 19a. Informant's Name/Relationship (Type. Print) 3501 Howard Park Avenue Apt.#311 Gwynn Oak Ruby Carlton-Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD permit. Page Department o Important: If any In|ury or 10-06-10 Garrison Forest 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. OBSTRUCTIVE PULMONARY Immediate Cause (Final CHRONIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a or Vital Records, P.O. 9 Unknown s been signed by the 2 should be detachε 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown ARTER DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an ALZHEIMERS autopsy pade 2 No certificate or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director. Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ပို this After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident within 24 hours after death

To the Funeral Director; A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number mila D302 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 COCHRAVEN COULEVAND. MOZR18 miller and 15 S 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#11perINF, G908, 10, 12, 2010, WS
State of Maryland / Department of Health and Mental Hygie (2011) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)
Conrad William Johnson 2. Date of Death 3. Time of Death September 28 2010 **Physician** 3:30AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Baltimore - Towson Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex 1. M 2□ F **Funeral** Year) Months Days Hours Min. MD 218.26.605 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examinar must be notified at Ballimore MD Towson 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 E. Joppa Road, Apt. 301 21286 USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ₩ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items, 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 14 ack δ 3 ☐ Widowed → Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. FOYE Meade taministrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Johnson Holland Marie မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Janson 1234 Stella Drive Baltimone MD 21207 Department of Health Important; If item 27 any injury or other troone. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10 05 2010 Owings Mills, MD Jamison Forest 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility \ alighn C. Greene Tineral Services Liberty Road Randallstonn, MD 21133 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause Eiral Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): unknown Examiner UNGS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 □Yes 2 □No Month Day Year neral Director. After this certificate has been signed by the filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 □Yes 2 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural To the Hospital or Attendir within 24 hours after death. To the Funeral Director; A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D-12849 u colin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DY TOWSON MD ZIZOL 31. Date filed (Month, Day, Year) egistrar's Signature State

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Henry C. Klein Jr /Medical September 25,2010 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 12 Basilan Court Rosedale 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 17007H 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Months Hours Min. Days Director 178-44-0187 July 31,1953 Doylestown, Pa Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Myclical Examiner must be notified at Director Md. Balto. Rosedale 04/25/2010 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 Basilan Court Funeral 21237 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Deceus... Armed Forces? ¹ □Yes 2 🔼 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No þ If Yes, Give Year or Dates Specify: Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene important: If item 27 is marked other than "any injury or other traumatic event, the Mar Elementary/Secondary (0-12) Masters Degree Electrical Engineer Aircraft 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry C. Klein ပ Gladys S. Schiele 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry C. Klein Father 154 Ash Way, Doylestown. Pa. 18901 injury or other Baltimore. のといく 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Doylestown Cem. 9-30-2010 4 Donation 5 Dother (Specify) Doylestown, Pa. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Nottingham, Md.21236 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Arteriosc condiquase u disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examil burial-tran exect Due to (or as a consequence of): Box 68760 requires that the death certificate be Physician/Medical the as attending for use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) P.0. the 9 Unknown ģ signed I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy Hospital or Attending Physician; The certificate perform Division of Vital 1 □ Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 MResidence 6 ☐ Other (Specify) 2 □ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only

cause of death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

30664

1700P

Birthplace (State or Foreign Country)

White

10d. Inside City Limits

Approximate Interval Between Onset and Death

Dav

2 No

Year

1 ☐ Yes 2 No

Reg. No.

Year

State Registrar

31. Date filed (Month

29b. Signature and title of certifie

30. Name and address of person who

Year)

1 - For State Registrar

Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sentembers GREGORY LYNN KISAMORE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie Baltimore Washington Medical Center Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) Jan 28, 1955 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗷 M 2 🗆 F Days Hours 219-66-9636 West Virginia Director Yrs. Usual Residence of Decedent 10b. County 10a. State death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1364 Edna Road 21122 USA 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Yes, Give 10 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: "natural" 3 Widowed 4 Divorced Year or Dates. 1972–78 White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Kisamove Masonry Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental h ည Page 1 and 2 should be Melvin Emory Kisamore Twila Juanita Kisamore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 Beverly Hatfield (Sister) 2736 Norfen Road, Baltimore, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any injury or o 1 🗷 Burial 2 🗌 Cremation 3 🔲 Removal from State Glen Haven Mem. Pk. Oct 1, 2010 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland 21. Signature of Funeral Sauce Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. Kevin E Ecker 237 Fast Patapsco Avenue, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death 1 ON Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to humediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician I be detached for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy pertormed? Yes 2 No 2 1 No 1 🗌 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗆 Yes 2 1 No Other: ျ 1 Inpatient ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 Tyes 2 🗌 No Accident the Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d Date signed (Month, Day, 29b. Signature and title of certifier september 2010 30. Name and address of person who completed TO 2016 r's Signature State

/DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Dav **Physician** Yea POPPMBER 20 ZOIC /Medical Facility Name (If not institution, give street and number) ounty of Death Town, or Location of Death Examiner If Unde If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Apr 7, 1934 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 💢 F Minnesota 76 Apr Director 476-32-1231 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10051 Windstream Drive Unit 2 21044 Funeral USA permit. Pages 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must once. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify: white 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) real estate agent properties 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Jrebal Lolita Hewer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra McPhillips/daughter 100 Tulip Drive Gaithersburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of peral Service Licens 22. Name and Address of Facility Ronald tate Anatomy Board altimore, MD 2120 655 W. Baltimore Street more, 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neta Physician STATI 5 months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner Directo (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 1 ☐ Yes 2 No Certification: To Be 26. Place of Death Check onl one) Hospital: Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Accident 5 ☐ Pending investigation ours after death. veral Director: Af 1 Tyes 2 No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O1: 20A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince outhan Ma 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🖭 Months Country) Director infant Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Examiner must be notified 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Mever Married 2 ☐ Married Completed by 2 1 No __ Yes Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify If Yes, Give and Mental Hygiene.
is marked other than "natural", 3 Divorced Oak Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) infant infant infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 101 Haxarder hanner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7503 Surratts Road Clinton, MD 20735 Southern Maryland Hospital of Health a other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Important: If ō 1 Burial 2 Cremation 3 Removal from State injury 4 □ Donation 5 ▼ Other (Specify) in state Signature Tuneral Service Licen Xon 1d 5. Val 23 Partend Address of Facility Board 655 W. Baltimore Street 222 Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDIAC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner REMATURIT Sequentially liet conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown of Vital Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown has been signed by 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform certificate | 2 No 1 Yes Yes within 24 hours after death.

To the Funeral Director. After this certifica completed filled in by the funeral director, it Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending work? 1 Natural Division 2 🗌 No Investigation
6
Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who

31. Date filed (Month, Day, Year)

13 Surrosts Rd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death r <u>28 2010</u> Physician/ LeDuce 1:13 P September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Glen Burnie 235 Turnwood Drive 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Year 1925 219-18-8060 Months Days Hours Min. April II. 85 Mary Tand **Director** Usual Residence of Decedent fshow with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene. Important: If item 27 is marked other there any injury or other traument. 235 Turnwood Drive 21061 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Yes, Give Specify: White Completed 3 X Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Westinghouse Corp. Silk Screener Ó Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Green Charlotte Baer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darryl J. LeDuce (Son) 235 Turnwood Drive, Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Glen Haven Memorial Park | 10/1/2010 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Sergice Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. _ 237 E. Patapsco Avenue, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Filysician ZHEIM EMENTIA disease or condition resulting in death) TIDUY Medical Due to (or as a consequence of) Examiner 6 months Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 💆 No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à PARALYSIS AGITANS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏿 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 A No 1 ☐ Yes 2 ₺ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ျှ 1 🗌 Yes 2 🖼 No 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 \square Pending 1 🗆 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D004 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) 1209A

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 30669 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sept. Margaret Lord Medical 2010 9:00 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 320 Seward Ave. Baltimore Anne Arundel 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 220 22 1322 1 M 2 X F Days Director Months Hours 82 (Month, Day, Year) 07/20/1928 Maryland Usual Residence of Decedent 3a or 28a-f show t be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Baltimore 1 Tes 2 No 10e. Street and Number 10f. Zip Code ns 23a c c must b 10g. Citizen of What Country? Funeral 320 Seward Avenue 21225 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black, White, etc. 3 X Widowed 4 Divorced 1 ☐ Yes 2 No Specify. Completed Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Machine Operator Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leo Kelly Mary Creighton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon Lord / Son 5 Carriage Lamp Court Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗔 Removal from State 10/01/2010 4 Donation 5 Other (Specify) Cedar Hill Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 0 0 disease or condition **Medical** resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant yes, outcome of pregnancy
Live Birth 2 Fetal death in the past 12 month 23d. Date of delivery 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforr 2 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No ၉ 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Watural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Dr. Harjit Singh

3 0 2010

31. Date filed (Month, Day, Year)

5410 A Ritchie Highway

37 Registrar's Signature

Baltimore, Maryland 21225

30670

			For Amend Item State Registrar	s 23e,29d	per d	r . , g9	08,10/13/ tificate of l	2010dhБ Death		Reg. No.				
	Dhusisi		1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year				
	Physici: /Medic		Robert Warre						5:32 AM					
	Examin	er	4a. Facility Name (If not institution, gi			Location of Death	1		4c. County of Death					
Apr. all	· · · · · · · · · · · · · · · · · · ·		427 Bathurst Ro 5. Social Security Number 6.		e (In vrs. la	st birthday)	Catonsvi If Under 1 Year	.1.1e If Under 24 Hrs.	8. Date of Bir	th	1timore 9. Birthp	lace (State or Foreign		
	Funeral Director		218-46-0119	4157 M OF E	65	Yrs.	Months Days	Hours Min.	Jan. 23	ay, Year)	Mary			
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits		
	Maryl f sho	to	MD Baltim	ore	C	atonsv	7111e			1 □Yes 2 ☑ No				
	r 28a	irec	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Coun	try?		
	th wit	al D	427 Bathurst Roa	d				1228			SA			
	r dea	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puerl	Specify Yes or No to Rican, etc.))- 1	 Race - Americ Black, White, e 			
36	, or if		1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑Yes 2 ☐ I If Yes, Give Year or Dates:		71	1 □Yes 2X No	Specify:			Specify: Wh	ite		
0	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examinan must be putified at	Completed by	15. Decedent's I	Education	1703	16a. Dece	dent's Usual Occup	pation	-t-l	16b. Kir	nd of Business/Inc	dustry		
215	hin 72 e. an "na	ple	(Specify only highest g	rade completed) College (1-4or 5	j+)	`life. I	kind of work done OO NOT use retired	auring most or wor d)	rking					
21	e filed within al Hygiene. I other than ' vent, I're I're	Con	12			Meat (Cutter	18. Mother's Nai	/First Middle		r Fresh	- 1		
nd	be file	Be	17. Father's Name (First, Middle, Las	st)										
Maryland 21215-0036	s t and 2 should be f Health and Mental fem 27 is marked o other traumatic ev	은	Carl Adam Lueckert Mildred Louise 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number,											
Na	d 2 sl Ith an 17 is r traur		Cynthia Lueckert				Bathurst							
	s t and 2 of Health item 27 i	-	20a. Method of Disposition		20b. Pl		sition (Name of natory or other place		Date		cation - City or To	own, State		
E	Page: nent o int: If		1 ⊠ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			-	v Mem. Pa		/2010	Syke	sville,	MD		
Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or of once.		21. Signature of Funeral Service Lic	ensee		22	Name and Addre	ess of Facility St	erling A	Ashto	n Schwal) Witzke		
<u> </u>	9 9 E E 9		Joseph y. Kell		0033	3	Tuneral H 630 Edmo	ndson Av	enue; C	atons	ville, 1	ID 21228 Approximate		
			shock, or heart failure. List only one cause on each ine.											
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a_ ne	tast	anc	Croke	rectal	Cance	<u> </u>		30 month		
	/Medical Examiner	ı	resulting in dealing	Due to (or as	a consequ	ence of):								
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	ence of):								
	outed ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	G.										
o,	e exec ian an ırial-tr	Exa	resulting in death) Last	Due to (or as	a consequ	ience of):								
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			IF FEMALE:	23c. If yes, outcome	of pregna	ncv					23d. Date of deliv	/erv		
Вох	death cer e attendin ed for use	Physician/N	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	2 🗌 Fetal	death 3	☐ Ectopic pregnand ☐ Other (specify) _	cy			Month	Day Year		
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s, P.	Physician: The law requires that the this certificate has been signed by the ral director, page 2 should be detached.	by Pl	Part II. Other significant conditions	contributing to death t	out not resu	ılting in the u	inderlying cause gi	ven in Part I.	23e. Did			the cause of death?		
ğ	w require been sign should b								1	Yes 🔫	₽ No 3□ Pro	babiy 4 🔼 Unknown		
Record	law re as be 2 sho	Completed								opsy	prior to co	opsy findings available ompletion of cause of		
-E	: The law cate has I , page 2 s	Con							per 1 □ Yes	formed? 2 No	death? 1 ☐ Yes	2 X No		
Vital	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Ot Ot	hor	eath (Check only		A 17011			
of		년:	1 Yes 2 No 27. Manner of Death	28a. Date of Inj	ury	28b. Time of	IN 3 L DOA	4 🗆 Nursing	28d. Describe		6 ☐ Other (Spec ry occurred	ity)		
	Attending ir death. ector: After by the funer	ig	1 Natural 5 Pending 2 Accident investigat	(Month, D.	ay, Year)	Injury		rk?]Yes 2. □No						
Division	lor Attend after death Director; d in by the f	ifica	3 ☐ Suicide 6 ☐ Could not determine	Zoe. Place of II	jury - At ho	ome, farm, st	reet, factory, office		28f. Location City or To	(Street ar	nd Number or Ru	ral Route Number,		
ā	tal or s afte al Dir ed in	Certification:		/										
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best taminer: On the basis and manner s	of examina	wledge, dea tion and/or i	th occurred at the nvestigation, in my	time, date and pla opinion, death oc	ce, and due to the curred at the time	ne cause(s e, date an	s) and manner as d place, and due	stated. to the cause(s)		
	o the vithin of o the omple	Med	29b. Signature and title of certifier	and mainlest o			29c. Licen	se number		29d. Da	ate signed (Month	ı, Day, Year)		
	- S - O		hant (vale in	\sim 0		D4	6118		0ct	ober 5,	2010		
,			30. Name and address of person with	no completed cause of	death (Item	n 23a) (Type	, Print)	1 01	1		1	11.		
4.1			JANET COC	PER MD	7	141	Secur	ity B	Nd,	Win	SOY M	Ils MUZIZI		
	St	ate	31. Date filed (Month, Day, Year)		trar's Signa	d.	back		(

DHMH 17 Rev 1/2001

Laurance 15 Lahargove
Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene													
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Physician Medica	ı La		ward Lahargo	ue				2. Date of L Month	<u> </u>	A ZONO	2:03AM		
Examine	Coas	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death											
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Baltimore, oemit. Page 1 and Department of Hea Important: If item any injury or other	1 □ Buri. 4 🕅 Don	al 2 Cremation ation 5 Other (S		cem	e of Disposition (i etery, crematory o	Name of or other plac	сө)	Date	20c. Lo	ocation - City or	Town, State		
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S, P.O. ires that the signed by the doctorch doctorch doctorch doctorch	Fait ii. Other s	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the								the cause of death?			
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To the within To the comp										Day, Year)			
	30. Name and a	address of person w	ho completed cause of de	ath (Item 23a) (Type, Print)	D000	58410	>		2/24/1 D 2/8	10		
	6 HW	Aus a	Anti lo	1501	0 173	3	SANS	sung	w	0 218	02		
State Registrar	31. Date filed (1	SEP 3 0 20	10 Registra	's Signature	parke								

State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 1 0 30672 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Day Year Eunice F. McCullough 01:30 AM SEPTEMBER 28 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner N/A SAINT AGNES BALTIMORE HUSPITAL 8. Date of Birth
(Month, Day, Year)
4, 1918 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
West Virginia 6. Sex **Funeral** Months Days Hours Min 1 M 2 X F 92 218-28-1313 Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Modical Examiner must be notified at 10d. Inside City Limits 1 ☐Yes 2 📉 No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5743 Edmondson Avenue Funeral 21228 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or iten any injury or other traumatic event, Ite Medical Evansir and any injury or other traumatic event, Ite Medical Evansir en 1 ∏Yes 2 X 1 f Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify Specify: White ξ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Drapery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cecil Hill Frances Slingluff 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott H. McCullough, Son 147 Nunnery Lane Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory Inc. 09/29/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complication and trace as the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** BACTEREMIA DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** DAYS-WEEKS PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-tra Due to (or as a consequence of) Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed ATRIAL FIBELLIATION 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy CORONARY ARTERY DISEASE Division of Vital 2 **X** No 1 □Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be (funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 IX Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00070917 SEPTEMBER 28, 2010 900 CATON AVENUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BHAVAN DEEP BAJAO BALTIMEE, MID. 21229 31. Date filed (Month, Day, Year) legistrar's Signature State

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30673 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 23 Physician/ James J. Morse 2010 1:22 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6831 Annapolis Road Hyattsville Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral . Age (In yrs. last birthday, 8. Date of Birth 1 🎇 M 2 🗆 F Month, Day, May 8 74 Months Days Hours Min. Director Pennsylvania 160-28-1824 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Prince George's Hyattsville Maryland 1 🗆 Yes 2 🕱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20784 USA 6831 Annapolis Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc 1 X Never Married 2 Married 5-0036 1 ☐ Yes 2X No Specify: White If Yes Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Clerk Law Firm Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Floyd Morse Muriel Burns I and 2 should b f Health and Mei tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Ronald Morse, Brother 311 McPherson Street Warren, PA 16365 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. : 09/28/10 Baltimore, Maryland Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryl Momas Maryland 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Hours Acute Myocardial Infarction Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Arteriosclerotic Cardio Vascular Disease Yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy
☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 No 9 Unknown s been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has k completed filled in by the funeral director, page 2 autopsy performe 2 🗆 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Tes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner) in the best of my knowledge, death occurred at the land, date and place, and due to the cause(s) and manner stated.

Gentifying Numer plantioners To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only on 29b. Signatur d title of cert 29c. License number 29d. Date signed (Month, Day, Year) September 27, 2010 D32261 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person w Richard J. Feldman, MD 8116 Good Luck Road Lanham, Maryland 20706 31. Date filed (Month, gistrar's Signature State 3 0 2010 Registrar

1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ^{Day} 26. Nea1 Douglas Molloy, September Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Center Baltimore If Under 2 8. Date of Birth **Funeral X** M 2 □ F Months Days Hours Min 436-72-5520 58 Director Usual Residence of Decedent 28a-f shov 10a, State 10c. City, Town or Location Examiner must be notified at Director **VA** Fairfax Vienna 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 514 Meadow Lane, S.W. 22180 or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No 72 hours after Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give "natural", Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than, Elementary/Seconday (0-12) College (1-4 or 5+) **5+** and Mental Hygiene. Commercial Aircraft Aerospace Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nea1 Douglas Molloy Joyce Ellen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health aitem 27 i Andrea L. Lindeman, daughter 6572 123rd Avenue, S.E. Bellevue, WA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite ò 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 09/29/10 injury (4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, 299 Frederick Road Baltimore, MD 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Traumatic Brain Injury disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Fall off of Road Bike Sequentially list conditions, Due to for as a consequence of it any leading to immedia cause. Enter Underlying Cause (Disease or iinjury Exami or Attending Physician: The law requires that the death certificate be executed and-tran that initiated events resulting in death) Last Due to (or as a consequence of): burial-Physician/Medical Box 68760 the attending physical attending physical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death g 🗌 Unknown 9 Unknown P.O. à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 2 X No funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 \square No ၉ 1 Nonpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗌 Natural 5 Pending n 24 hours after death.

e Funeral Director: Al 09/25/10 1:47 PM 1 Tes 2 **X** No 2 X Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Public Roadway Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. MD 21710 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner sta 29a. Certifier completed (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the the 29b

Fall off of Road Bike 28f. Location (Street and Number or Rural Route Number, 2403 Park Mills Rd. Adamstown

1 ☐ Yes 2 ☐ No

30674

5:50

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2X No

Country)
Louisiana

2010

USA

Landry

White

98006

Inc.

Approximate Interval Between Onset and Death

29d. Date signed (Month, Day, Year) 30. Name who completed cause of death (Item 23a) (Type, Print) and

State Registrar

DHMH 17 Rev 7/2009

M.D

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death EE MEEKINS SEPT. Physician/ DG4SA M 2010 Medical 4c. County of Death 4b. City, Town, or Location of Death BALTIMORE 4a. Facility Name (if not institution, give street and number) Examiner GOOD SAMARITIAN HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Months Days Hours Min 73 219-26-7922 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland items 23a or 28a-f sho her must be notified at 0c. City, Town or Location BALTIMORE Director MD N/A 1X Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21206 3808 FORRESTER AVE 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. 0 þ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 12 Elementary/Seconday (0-12) Hygiene. life. DO NOT use retired) College (1-4 or 5+) GARDENS OF FAITH CEM. ADMINISTRATION permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 18. Mother's Name (First, Middle, Maiden Surname) LEE BOWMAN 17. Father's Name (First, Middle, Last) ပ JOHN SCHMIDT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD 21206 3808 FORRESTER AVE RONALD MEEKINS-SON 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) BALTIMORE, MD GLEN HAVEN CEMETERY 10/1/10 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, BALTIMORE, MD 21206 6415 BELAIR RD Part 1. If pter the disease, or co shock, or heart failure. List only blicktions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final enysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HEPATOMA 1 Yes 2 No 3 Probably 4 Unknown To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 🗌 No 1 Inpatient 2 FR/Outpatient 3 IDOA ျ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0018230 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

3 0 2010

SHAS

HEDHARAN, M. Dr., Gord Samantan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Donnie L. Martin	Martin State of Maryland / Department of Health and Mental Hygiene Certificate of Death										30676		
Physicia		1. Decedent's Name (First, Mide	fle,Last)	_	_				2. Date of Dea	th		3. Time of Death	
Medical Examin	ier	Donnie L							Septembe	r 25, 2010		1920 hrs	
		4a. Facility Name (if not instituti University Hospital	on, give street and nu	mber)		4b. City, Town Baltimore	n, or Location o	of Death		4c. County o	of Death		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1		er 24Hrs.	8. Date of Bir	th(MM/DD/YYYY	9. Birthr Foreign	olace (State or	
Director	1	215-86-5881	1XM 2_F	38	Yrs	Months I	Days Hours	Min.	10-2	7-71	Coun	itry) MD	
	ļ	Usual Residence of Decedent		100-100					·			04.1	
Maryland 28a-f show any d at once.		10a. State 10b. County	NA		Town or Locati	e						0d. Inside City Limits 1 X Yes 2 No	
the Mary	힐	10e. Street and Number 818 Carrol:	L Street			10f. Zip Coo			1	0g. Citizen of Wh USA		y?	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 N	farried Armed Fo	2 X No	If Y	es, specify Cu	uban, Mexican	, Puerto F	cify Yes or No tican, etc.)	White	, etc. A	frican	
s after		3 Widowed 4 Di 15. Decedent's Education (Sp	vorced If Yes, Give Yea or Dates:				No specify:		Specify: American Id of work done 16b. Kind of Business/Industry				
36 uin 72 hour t. than "natu dical Exar	Completed by	Elementary/Secondary (0-12 12th Grade				ost of working	life. DO NOT			Constr			
d with	탉	17. Father's Name (First, Middle	e, Last)	-	l	· · · ·	18.Mother	's Name (ame (First, Middle, Maiden Surname)				
215 be file ntal H rked ent, til	8	Leroy	Marti	in				nna					
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the <u>Medica</u>	의	19a. Informant's Name/Relation										Zip Code 21230	
MC 2 salth an 27 cm 27	-	Leroy Ma:	ctin-Fath		Place of Dispos				Dale	imore,			
Ore, of He If ite ther the		1 X Burial 2 Crematic	n 3 Removal fro	om Ctoto	crematory or oth rbutus	ner place)	•	l	01-10		-		
Baltimore, permit. Pages I an Department of He Important: If ite	-	4 Donation 5 Other 5		Α.			ress of Facility			l uneral	•		
Ba Permi Depa Impo injur		The use of Rame	Giran C.	\bigcirc								MD 21217	
Physician	寸	23a. Part I. Enter the disease, of failure. List only one cause	r complications that ca	aused the death	. Do not enter th	ne mode of dy	ing, such as c	ardiac or i	espiratory arr	est, shock, or hea	ırt	Approximate Interval Between Onset and	
/M- di al Examiner	Ì	Immediate Cause (Final diseas or condition resulting in death)	_{a.} Gunshot W	ound of Che							\rightarrow	Death	
		Sequentially list conditions,	b								\rightarrow		
	<u></u>	if any, leading to immediate cause. Enter Underlying Cause		consequence o	f):								
uted id ansit	Examiner	(Disease of injury that initiated events resulting in death) Last	Due to (or as a	consequence o	rf):								
	edical	UNPENDED	AMENDED										
Division of Vital Records, P.O. Box 68760 not the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the funeral director.		IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Ur	he 1 Live b	ant at time of de	2 Fe	tal death ner <i>(Specify)</i>	3 Ectopio	c pregnan	су	23d. Date of Month	delivery Day	y Year	
b. B. the de ched f	훕	Part II. Other significant cond	9 Olikilo		esulting in the u	nderlying cau	se given in Pa	art I.	23e. Did to	bacco use contril	oute to the	e cause of death?	
cords, P.O law requires that has been signed b	호								1 Yes	2 No 3	Probab	oly 4 Unknown	
rds, requir	ompleted								24a. Was autop			psy findings available impletion of cause of	
Vital Recoryysician: The law this certificate has I director, page 2 sl	Ĕ								perfor 1 ✓ Yes		eath? ✔ Yes	2 No	
tal F	Be C	25. Was case referred to medic examiner?			,		lace of Death	,			7		
of Vi ing Physi After this	위	1 Yes 2 No 27. Manner of Death	Hospital: 1 🗸 1	of Injury	ER/Outpatient 28b. Time of li		Other ₄			Residence 6			
ion c tending eath. tor: Af the fun	aţiol		ding Sep 25,	.Day.Year) 2010	1709 hrs	1	Yes 2	No S	ubject sho	t			
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 Cou	ald not be 28e. Place	e of Injury - At he Townhouse		-	ce building, et		or Town, S			Route Number, City	
To the Hospital within 24 hours To the Funeral completely filled			Physician: To the bes aminer: On the basis of										
To t withi To tl	Medical	29b. Signature and title of certif	and manner s				ense number			29d. Date signe			
	_	(Landort	ems			0.	.C.M.E.			September	26, 20	10	
	ſ	30 Name and address of perso Laron Locke MD.	n who completed caus Assistant Medica			Street. Ba	altimore, M	D 2120	1				
Sta	ite	31. Date filed (Month, Day, Year) 32. Re	strar's Signatu	ITA	a Kel							
Ponistr	_	AFD 4	0.2010	Pi I									

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 30677 State Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ Raymond Edward Maurer 2010 12:15 September Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 1162 Wharf Drive Pasadena Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 F Director 212-26-9069 81 Pennsylvania Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f sho: 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1162 Wharf Drive 21122 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☒ Yes 2 ☐
If Yes, Give Black, White, etc. 1 Never Married 2 Married 2 No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify. 3 Divorced 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Post Engineers Pipe Fitter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Henry Amon Maurer Elizabeth Thomas permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doloris Maurer (Wife) 1162 Wharf Drive, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Sept. 28,2010 4 Donation 5 Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Se tuentially list conditions if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ched for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No detached for Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed within 24 hours after death.

To the Funeral Director: After this certificate 2 1 No 2 🗸 1 🗌 Yes filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{\text{\text{Nursing Home}}}\) Nursing Home \(5 \) Residence \(6 \) Other (Specify, 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Toleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and **β**tle of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4304 MOUL GARCOM 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Fredrick Alan Munker 8:20 P.M Sept<u>ember</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Anne Arundel Glen Burnie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min New York 55 216 48 8724 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits Director 1 🗌 Yes 2 🗓 No Anne Arundel Pasadena Maryland 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? ems 23a or must be r Funeral 8222 Meadow Wick Court U.S.A. 21122 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ō Examir þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 Divorced 4 Divorced White is marked other than "natur aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Auto Sales Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fredrick Joseph Munker Virginia Lent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. Darlene Munker / Wife 8222 Meadow Wick Court Pasadena, Maryland 21122 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔲 Burial 2 🙀 Cremation 3 🗀 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 10/01/2010 Bayview Crematory 21. Signature of Funeral Service ! 22. Name and Address of Facility Gonce Funeral Service, P.A. Tems Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ 10 fac 2 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🔲 Yes 5 Pending 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical

REDERICK

Registrar DHMH 17 Rev 7/2009

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completed

29a. Certifier

(Check

29b. Signature and title of certifier

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Certifying Nursa Practioner: To the best of my knowledge, de

32. Registrar's Sig

30. Mame and address of person who completed cause of death (Item 23a) (Type, Print)

u,

1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

d at the time. date and plane, and due to the

29d. Date signed (Month, Day, Year) - 28-10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 24 2010 Physician/ 11:50 PM Ann B. Martin Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** OSPITAL GNE5 BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Month, Day, Year) ine 28,1932 1 □ M 2 🖾 F Months Davs Hours 213-30-4471 Director 78 Maryland June Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Catonsville MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 108 Fairfield Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes fif Yes, Give altimore, Maryland 21215-0036 White 1 ☐ Yes 2 A No Specify: Specify: 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ڡ Hilda Coar Richard B. Bockmiller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John M. Martin, Sr. Husband 108 Fairfield Drive; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State injury or 9/29/2010 Atlantic Crematory Glen Burnie, MD Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catons Ville, Inc. Si mature of Funeral Service Liceru MD 21228 Edmondson Avenue; Catonsville, 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ROGRESSIVE Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 for use as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No g 🗍 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 \square Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24 hours after death. Funeral Director: After this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed the Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner? 2 **N**o Other: 1 🗌 Yes ပ 1 🗹 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mannet of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 To the 29b. Signature and title of certifie INTERHAL MEDICINE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAIDEN Choice LA, CATOUSVIlle, MO

DHMH 17 Rev 7/2009

State Registrar

BOCKMille

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death
Month 3. Time of Death Physician/ : 10 A. M. George W. Moller Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 6. Sex If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 22, 1922 Country)
Maryland 1 52 M 2 D F Hours Director 212-16-9143 Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits death with the Maryland notified at Director 28a-f 1 Tes 2 No Anne Arundel Linthicum 5 10f. Zip Code 10g. Citizen of What Country? Funeral 530 Fountain Drive 21090 USA . Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. X Yes 1 Never Married 2 X Married 2 No Completed by Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Defense Experimental Molder Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ George W. Moller Pauline Werschnitzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Moller Wife 530 Fountain Drive; Linthicum, MD 21090 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lorraine Park Cemetery 10/2/2010 Woodlawn, MD 22. Name and Address of Facility Sterling Ashton Schwal Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 neral Se vice Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each inc. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ nnw disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 🗌 No as been signed by the a 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 ☐ Yes 2 ☐ No ☐ Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 \square Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the rivering within 24 hours after death.

To the Funeral Director: After the Date of injury Manner of De 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 2 Accident 1 Yes 2 No Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 🖆 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c. License number 2010 Name and address son who completed cause of ath (Item, 234) (Type, Print) 30 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3068 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 James Allan Miller September 5:48 AMM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 ... F July 12, 1942 Massachusetts Director 02 - 32 - 844268 Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at Director MD Wicomico 1 Yes 2 No Pittsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 34615 Warren Road 21850 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 0 small engine mechanica golf courses Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeff Harrington/friend 32230 Shavox Road Salisbury, م Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 00 1 Burial 2 Cremation 3 Removal from State 20 4 Donation 5 Other (Specify) in state State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Signature of Funeral Septi ice Licensee S. Wade 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** ro-inter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine ue to (or as a consequence of): physician and the burial-transit that the death certificate be executed neama that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p IF FFMALE 23c. If yes, outcome of pregnancy
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1 Yes 2 No Month Vear Day Pregnant at time of death ed by the a detached f 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, cate has been sig page 2 should b Completed 1 Yes 2 No 3 Probably 4 W Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1- Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 Yes 2 No Investigation 6 Could not be . Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

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Registrar's Signat

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3	/Medic Examin		4a. Facility Name (If not institution	n, give street and nun			4b. City, T	own, or	Location o	of Death		4c. C	county of Deat	h	
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	Funeral Director		5. Social Security Number 216-16-8145	6. Sex 1⊠ M 2□ F	7. Age (In yrs. I 86	Yrs.		Days	Hours	Min.	(Month, Da	y, Year)	Co	yland	or rotetytt
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	ems 2	Funeral	11. Marital Status	12. Was Dece Armed Fo	dent Ever in U.	S. 13.	Was Decede	ent of His	spanic Ori	gin? (Specify	/ Yes or No an, etc.))- 1·	4. Race - Ame Black, Whit		
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Vita	Physician: The this certificate har director, page	Be	25. Was case referred to medica examiner?	Hospital:				Othe	Ar:	e of Death (C					
0		1: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date	of Injury	ER/Outpatie		8c. Injun	4 🗖 INI		5 ☐ Resi		☐Other (Spe coccurred	ecify)	
ion	Attending F r death. ector: After by the funera	atior	1 ☑ Natural 5 ☐ Pendii 2 ☐ Accident investi	gation	th, Day Year)	Injury	М		<br Yes 2□	No					
Division or Vital Records,	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ained 200. Flace	of injury - At hong, etc. (Specif	ome, farm, st	reet, factory	, office		28f		(Street and wn, State)	d Number or R	ural Route Nu	mber,
Ω	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I		29a. Certifier 1 Certifyi	ng Physician: To the	best of my kno	wledge, dea	th occurred	at the tin	ne, date a	nd place, and	d due to the	e cause(s)	and manner a	s stated.	
	n 24 h	Medical		Examiner: On the b											(s)
	To the vithin To the comple	Ň	29b. Signature and title of certific	er			290	. License	e number				e signed (Mon		
R			ants april	MD		00.) (=		NA	10	09		76	DTEM	per2	8,2010
11			30 Name and address of person	•				ha	ice	Lan	6 .	3,14	ptem	MD 2	11228
	Sta	ate	31. Date filed (Month, Day, Year	0 0 201 B2. F	tegistrar's Signa	ature	has	Ked		······	/		(11016	1	
	Regist	rar	SEP	302010	Leaves	Ju.	12 000	-							

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Marylan		artment of F tificate of D			71	010	30683
			Registrar 1. Decedent's Name (First, Middle	Last)		Cer	uncate or L	-	2. Date of Dea	Reg. No.		3. Time of Death
	Physicia Medio		Eugene O	wens							2010	6'.07P M
	Examin		4a. Facility Name (if not institution,	-			4b. City, Town, or	Location of Death	1	4c. Count	y of Death	
***************************************	Funeral		Seasons Hospi 5. Social Security Number		st Hos			1stown I if Under 24 Hrs.	■ 8. Date of Birt		timor	e olace (State or Foreign
	Funeral Director		213-60-7334	1 🔀 M 2 □ F	49	Yrs.	Months Days	Hours Min.	May 16	Year) 1961	Coun	try)
	ow t	L	Usual Residence of Decedent 10a, State 10b, County		10- 6	y, Town or Lo					11000	
	arylan a-f sh fied a	cto	MD Balti	m 0 34 0	100. 010							0d. Inside City Limits 1 ☐ Yes 2√☐ No
	or 28	ä	10e. Street and Number	more		Бат	timore 10f. Zip Code			10g. Citizen of	What Cour	
	with t	Funeral Director	4112 Balmoral C	ircle			2	21208		US	A	
	death item		11. Marital Status	12. Was Deced	ent Ever in U.s	S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- p Rican, etc.)		ce - Americ	
35	al", or	d by	1 ☑ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1	☐ Yes 2 No	Specify:		Specify		
Š	hours natur iical E	lete	15. Deceder	Year or Date	es.		ent's Usual Occup		unk	16b. Kind of E		
9500-61212	s filed within 72 hours after death with the Maryland tal Hygiene. 3d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	(Specify only highe Elementary/Seconday (0-12)	st grade completed) College (1-4	1 or 5+)	(Give F life. D	one of work done of NOT use retired)	luring most of wor	king			
7	iled withii I Hygiene other th	BeC	12 17. Father's Name (First, Middle, L	4				40. 54-45-2-2- 51-2	(Find Maiddle	M-: / C	1	
Maryland		2	Eugene Herbe	•	Jr				ne <i>(First, Middl</i> e, . uise Har		<i>ie)</i>	
ary	should I and Me is marl raumati		19a. Informant's Name/Relationsh			19b. Mailin	g Address (Street a				State, Zip 0	Code)
Σ.	nd 2 s ealth a m 27 i		Louise H. Owe	ns/mother		7 S1	ade Avenu	ie #112 B	altimore	MD :	21208	
<u> </u>	ge 1 and 2 should be nt of Health and Men I fitem 27 is marke or other traumatic		20a. Method of Disposition 1 Burial 2 Cremation	3 ☐ Removal from S			sition (Name of natory or other plac	e)	Date	20c. Location	- City or To	own, State
saltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		4 N Donation 5 Other (S	/ //		1 00	Name and Address	on of Facility				
ğ	Depis Impo any i	V	21. Signature of Funer. Service Land 10	Wade & D	irecto	s St	Name and Addres Anat Itimore.			Baltim	ore S	street
			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that ca	used the deat					est,		Approximate Interval Between
	Ph_sician/	2 10	Immediate Cause (Final disease or condition		hogeaL	CANI	er					Onset and Death
	Medical Examiner		resulting in death)	_ d	r as a consequ	uence of):						
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (o	r as a consequ	ience off.						
	ited d ansit	Examiner	Cause (Disease or linjury	_	, as a sensoqu	301100 0.7.						
	execu an and rial-tra	Ë	that initiated events resulting in death) Last	Due to (o	r as a consequ	uence of):						
20	icate be executed physician and s the burial-transit	edical		d								
200	ertifica Iding page as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna	ncy				224 D	ate of delive	on
POX	eath c atten d for u	Physician/M	in the past 12 months?	1 Live B	inth 2 ☐ Feta antat time of o	ıl death 3 🗀	Ectopic pregnanc Other (specify)	у			onth	Day Year
	t the d by the tacher	Phys	g 🗌 Unknown	g 🗌 Unkno					1			
Э.	es tha igned be de	by	Part II. Other significant conditio	ns contributing to dea	ath but not res	ulting in the ui	nderlying cause giv	en in Part I.	23e. Did to	/		ne cause of death?
	requir	etec		-					24a. Was a			psy findings available
Vital Records,	e has l	Completed							autop	sy med 1	prior to co death?	mpletion of cause of
<u> </u>	an: Th tificat tor, pa	0	25. Was case referred to medical				26. Pla	ace of Death (Che			1 L Yes	
	hysici his cer I direc	To B	examiner? 1 Yes 2 No	Hospital:	npatient 2 🗆		t 3 🗆 DOA Othe	r: 4 Nursing H	ome 5 🗆 Resid	ence 6 Ot	n-Runer ner Specify	thospice
VISION OF	ling P	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	28a. Date of (Month)	f injury , <i>Day</i> , Year)	28b. Time of injury	28c. Injury work	?	28d. Describe h	ow injury occur	red	
SIOI	Attenc death ctor: y y the	Certificate:	2 Accident Investig	ot be	of Injury - At ho	me. farm. stre	M 1 L	Yes 2 □ No	28f. Location (S	treet and Numh	ner or Rural	Route Number
5	al or / s after il Dire ed in b		4 ∐ Homicide determi		g, etc. (Specify		,,,		City or Tow		or or nara	rroute rumos,
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours affard eath. Within 24 hours affard eath. To the Funeral Director. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medical Ex	Physician: To the best caminer: On the basis Nurse Practioner: To	of examination	and/or invest	gation, in my opinio	n, death occurred a	at the time, date ar	nd place, and du	ie to the cai	use(s) and manner stated.
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	-		30. Name and address of person v S Paja pakst 31. Date filed (Month Pay, Year) SEP 3 0 2	ho completed cause	of death (Item	23a) (Type, P Av.	S- 203 -	Baltim	NOTE, MID	212	09	
1	Stat Registra	te ar	31. Date filed (Month, Pay, Year) SEP 3 0 2	010 33 Rec	gistrar's Signat	1. pa	· Ked					

			For State	State of Marylan		artment of I			71111	30684
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	incate of i	Jealii	2. Date of Dea	ath	2 Time of Dooth
	Physicia Medic		WILLIAM	PFEIFER				Month O	7 Day 26 Year	10 9:05 PM
	Examin	er	4a. Facility Name (if not institution, give s			4b. City, Town, o			4c. County of De	ath
محدر -	Francisco		GOOD SMM ARITM 5. Social Security Number 6. Sex			If Under 1 Year	TMOKE		N/A	irthplace (State or Foreign
	Funeral Director		219-10-4226 ¹ X	M 2 □ F	Yrs.	Months Days		Min. (Month, Day DEC . 24	, Year) 9.5	ountry) MD
	d t	Ĺ	Usual Residence of Decedent 10a. State 10b. County	100 Cit	. Town or Lo	netice				10d. Inside City Limits
	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Funeral Director	10a. State 10b. County N/A	BA	LTIMOR	Œ				1 Yes 2 No
	the M	Ę	10e. Street and Number			10f. Zip Code	-		10g. Citizen of What C	
	s 23a	nera	4113 WHITE AVE			21206			USA	
	death r item iner n			12. Was Decedent Ever in U.S Armed Forces?		Was Decedent of H f Yes, specify Cuba	ispanic Origin? เก, Mexican, Pเ	(Specify Yes or No- uerto Rican, etc.)	14. Race - Am Black, Wh	
990	s after al", o Exam	Completed by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 No If Yes, Give Year or Dates.		1 ☐ Yes 2 ☐ X No	Specify:			HITE
2	hour hatur dical	olete	15. Decedent's Edu (Specify only highest grad	ucation	16a. Deced	dent's Usual Occup	ation	warking	16b. Kind of Busines	s Industry
2	hin 72 ne. than ' te Me	mo	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	O NOT use retired)	uning most of	working	EASTERN	
O O	ed wil Hygie other ent, th	Be	10 17. Father's Name (First, Middle, Last)		l LA	BORER	18 Mother's	Name (First, Middle,	STAINLESS Maiden Sumame)	STEEL
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ျ	UNKNOWN					PFEIFER	maiden damane,	
lary	should and N is ma auma		19a. Informant's Name/Relationship (Typ						, City or Town, State, Z	Zip Code)
<u>ა</u>	and 2 Health em 27 ther tr		AGNES PFEIFER-WIFE 20a. Method of Disposition			WHITE A	VE		, MD 21206	
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	emetery, cren	sition (Name of natory or other plac)F FAITH	·e)	Date 7/1/10	20c. Location - City of BALTIMORE	
alt.	mit. Poartme	1 13	21. Signature of Funeran Service Licenser						PEL FUNERA	
m —	Deg	į 13	X 1000		1	15 BELAI			, MD 21206	
			23a. Part 1. Injer the disease, of compli shock or heart failure. List only one	cations that caused the deatle cause on each line.	h. Do not ente	er the mode of dyin	g, such as card	diac or respiratory arr	est,	Approximate Interval Between
	Physician/ Medical	10	Immediate Cause (Final disease or condition resulting in death)	ACUTE ST		TON MY	CARDI	AL INFAR	CTION	Onset and Death
30,000	Examiner		Toolaning wir dealtry	Due to (or as a consequ	ience of):					6 Hours
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	bue to (or as a consequ	ierice oij.					0 1104763
	cuted nd transit	Examiner	Cause (Disease or itinjury that initiated events							
_	oe exe ician a ourial-	dical E	resulting in death) Last	Due to (or as a consequ	ience of):					
9	cate to physical care to be the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of th	ledic	C	l						
89	oertif ending use a	an/N	200. Has acocachi prognant	Bc. If yes, outcome of pregnal 1 Live Birth 2 Feta	ncy	Ectopic pregnanc			23d. Date of d	elivery
ROX	death the att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of d		Other (specify)			Month	Day Year
л Э	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit		Part II. Other significant conditions con	tributing to death but not resi	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	bacco use contribute t	to the cause of death?
S,	uires t n sign uld be	Completed by	ATRIAL FIBRILL	ATION, PAN	CREAT	TC CANO	LER,	_ 1 🗆 ነ	′es 2 □ No 3 □ I	Probably 4 Unknown
S S	aw red as bee 2 sho	plet	HYPERTENSION	7				24a. Was a		utopsy findings available completion of cause of
ğ	: The la							perfor	med? death?	es 2 🗆 No
<u> </u>	sician certifi rector	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:		Othe	r:	Check only one)		
<u> </u>	g Physer this leral di	e: To	27. Manner of Death	1 Inpatient 2 2 28a. Date of injury (Month, Day, Year)	28b. Time of	it 3 □ DOA 28c. Injury	4 <u> </u>		ence 6 Other (Spe ow injury occurred	cify)
O	endin eath. or; Aft	ficat	1 M Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	injury	M 1 □	Yes 2 No			
DIVISION OF VITAL RECORDS,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify)	me, farm, stre	eet, factory, office		28f. Location (S: City or Town	treet and Number or Ri n, State)	ural Route Number,
ב	spital nours neral I		29a. Certifier 1 Certifying Physic	ian: To the best of my knowle	edge, death o	occured at the time,	date and plac	e, and due to the cau	ise(s) and manner as si	tated.
	he Ho lin 24 he Fu npleted	Medical	(Check 2 ☐ Medical Examine only one) 3 ☐ Certifying Nurse	er: On the basis of examination Practioner: To the best of my	and/or invest	igation, in my opinio	n, death occurr	red at the time, date ar	nd place, and due to the	cause(s) and manner stated.
	Voit Con		29b. Signature and title of certifier	MAN		29c. License		12	29d. Date signed (Mon	
			30. Name and address of person who cor	MD	220/05		-000		09/26	12010
ĺ			TANNIA H. JOS				MEVAR	D, BALTIM	ORE MARY	LAND 2/239
	Stat	_	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure 🚣	41		, , ,		
	Registra	ľ	SEP 3 0 2010	serve p.	19 00	CONTRACT				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept 20 Day 2010 Par Richard Pullen 4:30P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sykesville Brinton Woods Nursing Carroll Home Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MD Country) 1 🖾 M 2 🗆 F Min. 212-30-3039 9-29-1932 77 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Carroll Westminster MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 186 E. Green St. 21157 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 X Married 1 ¥ Yes 2 ☐ No If Yes, Give þ Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. 77 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Factory Assembler 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Pullen Mary Ann Fluharty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Anna M. Pullen-wife 186 E. Green St.,Westminster,MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Meadow Branch Cem 1 Burial 2 Cremation 3 Removal from State 9-24-10 Westminster, MD 4 Donation 5 Other (Specify) Signal Signal Service Ligensee 22. Name and Address of Facility Fletcher Funeral Home Homas 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Reur disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Vear Pregnant at time of death 2 No detached 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det δ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2 1 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 🗆 Yes 2 🗆 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

DHMH 17 Rev 7/2009

only one)

29b. Signature

nd title of ce

and address of person

31. Date filed (Month, Day, Year)

USINGS

on who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Nurse Proctioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4a,c,26 per dr.,2907,09/30/2010dhb Certificate of Death Reg. No. Amend Items For State Registrar 30686 Reg. No. 20 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month q Physician/ Day Year 200 2010 1:45 A Medical 4a. Facility Name (if not institution, give street and number)

4603 Luerssen Avenue 4c. County of Death Examiner 4b. City, Town, or Location of Death Bal timore MITS 6. Sex 1 X M 2 □ F If Under 1 Year 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreig 7. Age (In vrs. last birthday) **Funeral** Months Days Min 250-30-5851 84 Director Ma Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No Baltimore Cit MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4603 1206 2 verssen USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 No þ Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: 3 Nidowed 4 □ Divorced Completed ack 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) /Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, La မ 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Baltimore MD ZIZKO Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 4-2010 rrison Signature of Funeral Service Incenses augho 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Demen disease or condition resulting in death) 475 Medical Due to (or as a consequence of) Examiner month ix Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 2 **N**O 1 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital ျာ 1 Tes 2 No 4 Nursing Home 5 Kesidence 6 Kor 1 Inpatient 2 I ER/Outpatient After this 28a. Date of injury (Month, Day, Year) 28c, Injury at work? 1 🔲 Yes Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending Natural injury 5 Pending death. 2 🗌 No 2 Accident
3 Suicide Investigation within 24 hours after deati To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ٥ D006136

Registrar
DHMH 17 Rev 7/2009

State

2400

Kirk

Milland

Ave

Baltimore MP 21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m.D

egistrar's Signature

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DAV15

Year)

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HVERDIS

31. Date filed (Month, Day,

Michael Rugers 10-07406

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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eren,	•	4a. Facility Name (if not ins Harbor Hospital	stitution, give	street and numb	er)			Town, or more	Location o	f Death		4c. County N/			
Funeral Director		5. Social Security Number 217/74/4101	6. Sex	7. M 2 F	Age (In yrs. la	st birthday) Yr:	Mont	der 1 Yea		_	8. Date of Bird		Foreign	nplace (State or n ntry)Mary1ar	nd
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 Never Married 2 3 Widowed 4	_	12. Was Decedo Armed Force 1 X Yes f Yes, Give Year		lf \	es, spec	ify Cubai	spanic Orig n, Mexican, specify:	Puerto F	ecify Yes or No- Rican, etc.)	Whi	ite, etc. White	an Indian, Black	19
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Division of Vital Division of Vital To the Hospital or Attending Physician: within 24 hours after death. within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	Certification:	2 Accident 3 Suicide 6 4 Homicide	Investigatio Could not b determined	28e Place c	of Injury - At ho	ome, farm, stre	et, factor	y, office	building, etc	c.	28f. Location (S or Town, S		ber or Rui	al Route Numbe	r, City
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yr',		30. Name and address of	had ,	Completed causa	of death (Item	23a)	\perp	O.C.	.M.E. 			Septembe	er 27, 20	J10 	
`		Ling Li, MD As	sistant Me	edical Exami	ner 111	Penn Stre		timore,	MD 212	01					
Star Registra		31. Date filed (Month, Day	Year) 2010	32. Regi	strar's Signatu	parke									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Winifred Norma Stillmock September :15P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto. Nottingham 4006 Pinedale Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, August 1 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign Social Security Number Funeral 1 🗆 M 2 🗶 F Months Davs Hours Country) Maryland Director 90 218-03-1040 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Manyland of Health and Mental Hygiene. The state 23a or 28a-f sho ritem 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County Director 1 ☐ Yes 2 🗓 No MA Balto. Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4006 Pinedale Drive 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carrie L. Druery Philip P. Cavanaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nottingham, Md. 21236 Son 4006 Pinedale Drive Patrick Stillmock 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Page 1 Department of I Important: If it any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-27-2010 Baltimore National Balto. Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner monary Disease To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 2 No Yes 1 🗌 Yes 2 1 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 2 17 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 203

State Registrar

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		4a. Facility Name (if not institutio		umber)	- 4	b. City, Tov	wn, or Lo	ocation of	Death		4	c. County of		
		Prince Georges Hospi	tal Center			Chever	ly					Prince G	eorge's	·
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/iSi r Att ter de irect n by t	ertification:		sugation	e of Injury - At h			ffice bui	lding, etc.		8f Location	Street	and Number	or Rura	Route Number, City
Div ital or ral D	ert.	- Daicide Doan		reside	nce				Į,	or lown, lashing	state) stor	1, DC.	212	Terr. NE
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ပ	29a. Certifier 1 Certifying Pl	hysician: To the be	st of my knowled	lge, death occur					ue to the cau	se(s) a	ind manner a	as stated.	
o the ithin 2 the mplet	edical		miner: On the basis and manner s	of examination a										
5 7 8 7 8	₹ E	29b. Signature and title of certifie			1	29c. L	icense i	number			29d	. Date signe	d (Month	n, Day, Year)
		1116		/	111		O.C.M	.E.			Se	ptember	15, 201	10
		30. Name and address of person	who completed cau	se of death (Item	n 23a)						_			
		Russell Alexander MD		Medical Exan		Penn Sti	reet, B	Baltimor	e, MD	21201				
S	tate	31. Date filed (Month, Day, Year)	32. R	egis ar's Signati	ure A	bark	1						-	
Regis		SEP.	3 0 2010	Cleneur	1 1. 14	Parke								

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 30690 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 1:45 P M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Medical If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1 – 6 – 1 9 5 5 **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Days Months Hours Min. 4-66-702 Director 55 MD sidence of Decedent ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Finksburg 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2703 Wildorlyn Dr. 21048 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒No Black, White, etc. 1 Never Married 2 K Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes. Give Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Administration Systems Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Everett Grant Jarvis Jr Lillian Blanche Wilson permit. Page 1 and 2 should Department of Health and Me Important: If item 27 Is mari 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karl R. Schmidt-husband 2703 Wildorlyn Dr., Finksburg, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State South Carroll Crem 9/30/10 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature 6 Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home 1. Nomas 254 E. Main St.,Westminster,MD 2115 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death h sician/ Uremia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi 8 months metastatic colon cancer that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ☐ Live Birth 2 ☐ Fetal deat ☐ Pregnant at time of death for Month signed by the at d be detached for g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ lymphocytic 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has After this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27, Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Ger Mying Nurse Practioner: To the best of my knowledge, death occurs id at the time, date and clare, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 063737773 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) breen Baltimore MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Henry Smith 27 2010 3:45A Sept Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) 220-32-2863 1 **№**M 2 🗆 F Months Days Hours Min. (Month, Day, Year) 4-19-1936 74 **Director** MD Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Montgomery Montgomery Village 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10303 Ridgeline Dr. 20886 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian Black, White, etc. þ 1 X Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Landscaping 11 Landscaper should be filed w and Mental Hygi is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lord Baltimore Smith Mary Ann Askin Dorsey t. Page 1 and 2 should by thent of Health and Mer tant, If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 Shirley Richardson-Friend 10303 Ridgeline Dr., Montgomery Village, MD other 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important; If it
any injury or ot 1 Burial 2 Cremation 3 Removal from State South Carroll Crem 10/2/10 Winfield, MD 4 Donation 5 Other (Specify) Juneral Service Lice 22. Name and Address of Facility Fletcher Funeral 2 pomas 254 E. Main St., Westminster, MD Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Dear months Immediate Cause (Final Lung Cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for uses as the burlar-transit Cause (Disease or imjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 XNo 1 Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 🔀 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined City or Town, State) Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 29c. License number 9-27-2010 D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coleman 1355 Piccard Dr., Rockville, MD 20880 31. Date filed (Month, Day 's Signature Registr

DHMH 17 Rev 7/2009

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, 3. Time of Death Month 6:31 PM **Physician** 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Locetion of Death Examiner Baltimore Franklin Square HOSPITA 0 da 7. Age (In yrs. last birthday)
Yrs. 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number **Funeral** M 2 🗆 F Months Days Hours Min. 237-30-2682 Usual Residence of Decedent Director 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10a State 10c. City, Town or Location 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director ttinaha Street and Number 10g. Citizen of What Country? or items 23a or 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No ģ Specify. "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "h Elementary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ anche 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1336 nant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an Nottingham 27 permit. Pages 1 and Department of Healt Important: If Item 27 any Injury or other 1 once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signat re of Funeral Ser 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerosic Cardiovascular heart **Physician** /Medical Due to (or as a consequence of): **Examiner** Due to (or as a consequence of): sague fially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed y per chalesterolemia
Due to (or as a consequence of): use as the burial-trans and been signed by the attending physician should be detached for use as the burial P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnency
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) □Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 1 □Yes 25 Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signatu 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

Baltimore

and address of person who completed cause of death (Item 23a) (Type, Print)

Janr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ EPTEMB 2010 Η. Sanford Marv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE WASHINGTON MEDICAL CENTE ANHE EN If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Dec. 23 Months Hours Min **Director** 83 219-22-4664 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 USA 279 Gibson Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker O Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Armstrong Ε. Harrison Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 279 Gibson Road, Pasadena, Maryland 21122 Dana Garrett (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 09/29/2010 Atlantic/Crematory Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Functa Pervice License McCuiTy≏Polyffiak Funeral Home P.A. Mountain Road Pasadena, Marvland 21122 23a. P. . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final [©]hysician/ ONGELTINE HEART FAILURE sease or condition resulting in death) Medical Due to (or as a consequence of) ∠xaminer Securitary list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month 5 Other (specify) Yes 2 No ed by the a detached f 1 ☐ Yes ∠ ☐ 9 ☐ Unknown P.O. I signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 2 No 3 Probably 4 Unknown s been signated the Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform this certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No ☑ Inpatient 2 □ မ ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person

Physician /Medical Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

tiges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural" مه المصميم من من من من الم

Pages 1 and 2 should I nent of Health and Men

permit. Page Department o Important: If any Injury or Injury or

other t

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

Physician:

Hospital or Attending

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Examine burial-tra physician the attending use for ed by the a detached f should be has page 2 certificate funeral director. this After 1 within 24 hours after death To the Funeral Director: filled in by

Physician/Medical Be Completed by Certification: To

IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 25. Was case referred to medical examiner? Manner of Death 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

21784

MD

State

Medical

29b. Signature and title of certifier

Crathir filed (Month, Day,

31. Date

D

Registra

DHMH 17 Rev 1/2001

completely

and manner stated.

32. Regist

's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Folk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30695 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 2010 Elaine Sengstack Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring 3406 Hallaton Court If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) Virginia Social Security Number 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) Funeral 1 □ M 2 😾 F (Month, Day, Yea Director 82 578-34-8823 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2v No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3406 Hallaton Court 20906 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 【 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 ☑ Widowed 4 ☐ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) housewife own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Physician/ Medical **Examiner**

ဂ

Throdore Carlisle Crump

DEborah S. Wagoner/daughter

1 Burial 2 Cremation 3 Removal from State

19a. Informant's Name/Relationship (Type, Print)

4 Donation 5 Other (Specify) 21. Signature of Fineral Service Licensee

20a. Method of Disposition

Medical Certificate: To Be Completed by Physician/Medical Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760

21. Signature of Edneral Service Licensee ROPaLO			e nd Anatomÿ Boar imore. MD 212		55 W. B.	altimore	Street
23a. Part 1. Enter the disease or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not enter		ode of dying, such as cardiac	or respi			Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c. resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):		Parkuson	<u>'s</u>	Diseo	<u>50</u>	years
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ►No 9 □ Unknown			ic pregnancy (specify)			23d. Date of de Month	livery Day Year
 Part II. Other significant conditions cont	ributing to death but not resulting in the u	inderlyir	ng cause given in Part I.	2			o the cause of death?
					4a. Was an autopsy performed?	prior to death?	ntopsy findings available completion of cause of s
25. Was case referred to medical examiner?			26. Place of Death (Chec	ck only c	ne)		
1 🗆 Yes 2 🔀 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	nt 3 🗆	DOA Other: 4 Nursing H	lome 5	Residence	6 Other (Spec	cify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury	М	28c. Injury at work? 1 Yes 2 No	î —	escribe how inju		
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, fact	ory, office		ocation (Street a ity or Town, State		ral Route Number,
(Check 2 Medical Examine only one) 3 Certifying Nurse	ian: To the best of my knowledge, death or: On the basis of examination and/or inves Practioner: To the best of my knowledge, or	tigation,	in my opinion, death occurred a	at the tin	ne, date and plac	e, and due to the	cause(s) and manner stated.
29b. Signature and title of certifer		2	29c. License number		29d. D	ate signed (Mont	h, Day, Year)

Rockville

Lois Mamie Rector

20905

20c. Location - City or Town, State

9/2/2010

MD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15308 Aylesbury Street Silver Spring, MD

Date

State Registrar

Piccard

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 1647 **Physician** Boy Somerville 09 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore of Manyland Medical Ctr Baltimore University 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 09-21-2010 MD infant Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b, County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. W. don E. n. in at De notified anone. 1 Yes 2 No **Funeral Director** MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 IISA 627 E. 37th Street 12. Was Decedent Ever in U.S. Armed Forces? 1 []Yes 2 [] No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 V If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No black Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant unk 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Latasha Somerville ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 22 S. Greene Street Baltimore, MD University of MD Med Ctr 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specify) in state 21. Sign iture of Funeral Service icensee de State Anatomy Board 655 W. Baltimore Street Virector Baltimore, MD 21201 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Carse (Final **Physician** prematunt extreme disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) the is certificate has been signed by director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death. death. 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated.

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) merkal,

23

29c. License number

1583938018

29d. Date signed (Month, Day, Year)

09-21-2010

S Creene St, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 Turley Jacqueline Joan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Baltimore Washington Medical Center Glen Burnie 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar 11, 1937 9. Birthplace (State or Foreign 5. Social Security Number Birtnu-Country) MD **Funeral** 1 □ M 2**X** F Days Hours Min. 219-34-6731 73 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23 or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified any once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County Director 1 Yes 2X No MD Anne Arundel Glen Burnie 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral USA 7860 Shellye Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2XX No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Bernhardt Vogel Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD 21060 Mr. Norman Turley/ Husband 7860 Shellve Road 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory Oct 2,2010 Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 21. Signature of Funeral Service Services PA 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ arch 19 disease or condition) Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 month Month Day 5 Other (specify) Preonant at time of death the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page 1 les 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 🛂 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ eral Director: After this of filled in by the funeral dir 27. Manne Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: ✓ Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated curred at the time, date and place, and due to the cause(s) and manner stated curred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29c, License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 2 5 Hospital 202 21061 Glan Bur MD RURMEET

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ THOMPSON AMES 37 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BONSECOVES HOSPITAL BALTIMURE BALTIMORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 🗆 F 1-26-1943 212-40-2614 **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No MD na Baltimore 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 827 N. Arlington Avenue 21217 USA or items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify f Health and Mental Hygiene. Item 27 is marked other than "natural", Completed 3 Widowed 4 XDivorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12)
10th grade College (1-4 or 5+) Custodial GBMC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be James C. Thompson II Julia V. Wise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 4914 Crenshaw Avenue Apt D Balto, MD 21206 Marlene Cox-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt Carmel Cem 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 10-5-2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Inneral Service Licensee March East F/H 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ w disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed bunial-transi Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death SP 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy perform death? 1 Yes 2 No Yes 2 7 NO 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide 5 Pending s after death. 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signatore and title of certifie 29d. Date signed (Month, Day, Year) PHYSICIAN 9-24-10 57543 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

PREETIND GR

31. Date filed (Month, Day, Year)

SANDHU

32. Regisfrar's Signature

1940W. BALTIMURE ST. BALTIMURE, mp 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30699 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month THOMAS LEETS 14:40 2000 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death BAUTIMECH BALTINOL VA BALTIMOR. WSPITOL U Shary 8. Date of Birth (Month, Day, Year) 5. Social Security Number (In yrs. last birthday) 83 Yrs. 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or oreign **Funeral** 233-42-838 1 M 2 D F Hours Min. Country) Director West Usual Residence of Decedent ıral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director Baltimore Maryland Baltimore 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2817 Rose Avenue 21227 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 HWidowed 4 Divorced "natural" WW II Specify: Completed White Year or Dates. the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry within 72 h (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) 9th College (1-4 or 5+) Carpenter Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) : should be file n and Mental F is marked of William T. Teets Mary Elizabeth Shrout 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau George E. Austin Jr. / Soninlaw518 Old Riverside Road Baltimore, Maryland 21225 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 09/27/2010 Baltimore, Maryland Bayview Crematory 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 mus 23a. Part 1. Enter the disease, or social shock, or heart failure. List only npications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, be cause on each line. Approximate Immediate Cause (Final Onset and Death .Physician/ CHONIC OBSTRUCTU disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, it any leading to immediate cause. Enter Underlying Due to (or as a nonsequence of) Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death the detached P.O. ģ been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes 2 4 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examine? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ည 1 Inpatient 2 ER/Outpatient 3 I DOA this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 5 Pending (Month, Day, Year) 1 Natural injury within 24 hours after death.

To the Funeral Director. Af completed filled in by the fu 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 🜠 flurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title f cert 29c. License number 29d. Date signed (Month, Day, Year) D38686 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

JERRAND, MO. 10 N. Greene St.

Balto., MD 21202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene 4 U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Laura Turner 8:01 A M Septem ber 2010 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore 3820 W. Coldspring Lane Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Months Days Hours Min July 12, 1911 Mary land 99Yrs 214-24-7799 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA 3820 W. Coldspring Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🚺 No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: black 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk minister <u>religion</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Jones Lillian Menefee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Brook/niece 4834 Foote Street NE #103 Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 □ Donation 5 ☑ Other (Specify) in state 21. Signalure Funeral Service License 22. Name and Address of Facility State Anatomy Board 655~W. Baltimore Street Baltimore, MD 21201Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death heart failure. List only one cause on each line End-Stage (ardiomyopulhy Immediate Cause Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to lor as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 25. Was case referred to medica examiner?

Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the innerial director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Physician/

Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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Exami

Physician/Medical

Completed by

Be

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Certificate:

Medical

27. Manner of Death

1 Natural

2 Accident
3 Suicide

er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

within 72 hours after death

and Mental Hygiene.

permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau

Physician/

Baltimore, Maryland 21215-0036

								1 Yes 2 No 3 Probably 4 Unknown	1			
								24a. Was an autopsy performed 2 2 1 2 2 2 2 2 2 3 No 2 4 2 3 2 4 2 3 2 3 2 3 2 3 2 3 2 3 2 3				
to medical					26. Place o	f Death (Chec	ck on	nly one)				
No	Hos	spital: 1	ER/Outpatient	з 🗆	DOA Other: 4	☐ Nursing H	lome	ASSISTED LIVING FACILITY OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE	ク			
5 Pending Investigation		28a. Date of injury (Month, Day, Year)	28b. Time of injury	М	28c. Injury at work? 1 Yes	2 🗆 No	28d	d. Describe how injury occurred				
6 Could not b determined								8f. Location (Street and Number or Rural Route Number,				

4 LI Homicid	e determined	building, etc. (Specify)	City or Town, State)	
29a. Certifier	1 Certifying Physic	ian: To the best of my knowledge, death occured at the time	e, date and place, and due to the cause(s) and manner as stated.	
(Check	2 Medical Examine	er: On the basis of examination and/or investigation, in my opinion	on, death occurred at the time, date and place, and due to the cause(s) and manner stat	ted
only one)	3 Certifying Nurse	Practioner: To the best of my knowledge, death occurred at the	ne time, date and place, and due to the cause(s) and manner as stated.	

only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death	occurred at the time, date and place, and due to	the cause(s) and manner as stated.
9b. Signature and title of certifier Why make M.D.	29c. License number	29d. Date signed (Month, Day, Year)
ABRAINPARTICIO	D0057465	9177/10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith AY-5. 203 - Baltimore, MD. 21209. N'S. Rajapakse, M.D

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Mary M. Valentine рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 4c. County of Death Examiner Overlea N/H 9. Birthplace (State or Foreign Country) VA Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 7-15-1918 1 🗆 M 2 💢 F Months Days Hours Min 218-22-7883 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No na Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 6116 Belair Road 21206 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X☐ No Specify: Black Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Homes Domestic Worker 4th grade Be 18. Mother's Name (First, Middle, Maiden Surname) ဂ Elizabeth Woods Camey Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto, MD 21213 1731 E. Lafayette Avenue Elizabeth Tyler-Goddaught 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify) Arbutus Mem Park 9-30-2010 Arbutus, MD March East F/H 22. Name and Address of Facility Signature of Funer 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) Pregnant at time of death signed by the at d be detached fo Part II. Other cignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 1 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 prior to completion of cause of death?
1 ☐ Yes 2 ☒ No within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s 25. Was case referred to edical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Monral of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d. Date signed (Menth, Day,

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month. Dav. Year.

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of person who completed cause of death (Item 23a) (Type, Prin

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		-	For State Registrar	State of Maryland	•	tificate of D			JIETTE Reg. No∕⊃ ∩ 1	0 20702
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٠,	Examin		4a. Facility Name (if not institution, give s Harbor Hospital	treet and number)		, ,	Location of Death		4c. County o	of Death
	Funeral Director		5. Social Security Number 6. Sex 216 42 4473	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 02/91/0/1	1	9. Birthplace (State or Foreign Maryland
	//aryland 8a-f show tified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Anne A	,	Town or Local					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the Nis 23a or 2	Funeral Di	10e. Street and Number 6608 Rapidwater	Way Apt. 204		10f. Zip Code	1060		10g. Citizen of W	
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🗶 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		Vas Decedent of His Yes, specify Cubar ☐ Yes 2 🛣 No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		- American Indian, k, White, etc. White
Maryland 21215-0036	thin 72 hour ene. • than "natu he Medical	Completed by	15. Decedent's Edi (Specify only highest grace Elementary/Seconday (0-12)		(Give k life. DC	ent's Usual Occupa kind of work done di O NOT use retired) eptionist	uring most of workli	ng	16b. Kind of Bus	otor Vehicles
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	d 2 should raith and M n 27 is ma er traumat		19a. Informant's Name/Relationship (Type Teresa Sands / Da			g Address (Street a Brighton	nd Number or Rura Court			ate, Zip Code) aryland 21122
Baltimore,	Page 1 an ment of He tant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State ce	metery, crem view C	sition (Name of natory or other place Crematory	09/2	5/2010	Baltimo	city or Town, State
Balt	permit. Departimport any inj		21. Signs to of uneral Service Dicember	Iridge						vice, P.A. Maryland 21225
N.	nysician/		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.			g, such as cardiac o			Approximate Interval Between Onset and Death
مرن	Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a conseque						
	cuted nd transit	edical Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as a conseque						10.0
8	cate be executed physician and s the burial-transit	lical E	resulting in death) Last	Due to (or as a conseque	ence oi):					
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ls, P.O.	uires that the signed by ald be detac	ed by Ph	Part II. Other significant conditions con	ntributing to death but not resu	Iting in the u	nderlying cause give	en in Part I.			bute to the cause of death?
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on of \	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, etter this certificate has completed filled in by the funeral director, page 2	Certificate: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury work?	at 2		ow injury occurred	
Divisi	tal or Atters after de al Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (St City or Town		r or Rural Route Number,
	To the Hospi within 24 hou To the Funer completed fill	Medical	(Check 2 Medical Examin only one) 3 Certifying Nurse	Practioner: To the best of my	and/or invest knowledge, d	igation, in my opinior leath occurred at the	n, death occurred at time, date and place	the time, date an e, and due to the	nd place, and due cause(s) and man	to the cause(s) and manner stated. nner as stated.
	wit To		29b. Signature and title of certifier	2-19	0	29c. License	number	2	29d. Date signed	(Month, Day, Year)
			30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, P	Street	Bolt.	nore	12.4	feed 21225
	Sta Registra		31. Date filed (Month, Day, Year) SEP 3 0 2010	2. Registrar's Signar	far.	Kel				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Mor Physician/ 12:20 PM 29 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of Maryland Medical Center University Baltimore Year If Under 24 Hrs Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 🔯 M 2 🗆 F (Month, Day, 19, 28, Country) Maryland 215-28-3065 80 Director Aug 1930 Usual Residence of Decedent show or 28a-f shov notified at 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Woodstock Maryland Baltimore 10e. Street and Numbe 10g. Citizen of What Country? "natural", or items 23a or Funeral 2100 Ganton Green Unit #302 21163 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? 1 Xyes 2 No 1953-Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give White Completed 3 Widowed 4 Divorced 1959 Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County Inspector event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H

27 is marked of
traumatic even permit. Page 1 and 2 should be filt.
Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Basil Manley West Anna Elizabeth Tillmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2100 Ganton Green, Unit#302, Woodstock, Maryland 21163 Mary B. West. Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 9/30/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimroe, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atheroscleratic disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Et et U derlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
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	Physician		shock, or heart failure. List only i Immediate Cause (Final disease or condition			Cardia	vascular D	150000	0	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	2007010	043 64101 -	. 0446		
	LAGIIIIICI	J.	Sequentially list conditions,	b. Suptraces	s consequer oe of):					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.	,					
o,	be executed ician and burial-transit		resulting in death) Last		a consequence of):					
68760,	<u> </u>	dica		d						
Вох 6	death certificate be e attending physicii d for use as the bu	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		_			23d. Date of de	elivery
P.O. Bo	0 0 0	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live birth 4□Pregnant at 9□Unknown		☐ Ectopic pregr			Month	Day Year
Records, I	The law requires that the ate has been signed by the page 2 should be detache	by	Part II. Other significant conditions of	ontributing to death bu	it not resulting in the	underlying caus	e given in Part 1.		tobacco use contribute Yes 2 No 3 F	4.4
	ysician: The law is certificate has b director, page 2 s	Completed						24a. Was auto perfo 1 \(\text{Yes}	san psy prior to death? 2 No 1 Ye	autopsy findings available completion of cause of s 2 XNo
Division of Vital	Attanding Physician: r death. actor: After this certifica	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2□ER/Outpati	ent 3 DOA	26. Place of Deat Other: 4 Nursing Ho	1.4	o <i>ne)</i> idence 6 □Other <i>(Sp</i>	anihi)
10	H # H		27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Time	of 28c.	Injury at Work?		how injury occurred	ouny/
Siol	ttandir death. ctor: Af / the fu	catic	1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			М	1 ☐ Yes 2 ☐ No			
<u>></u>	al or At s after c il Dirac id in by	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	ry - At home, farm, s . (Specify)	street, factory, of	fice		'Street and Number or F wn, State)	Hural Route Number,
	To the Hospital or Attanding I within 24 hours after death. To tha Funaral Diractor: Atter completely filled in by the funer	Medical ((Check only 2 Medical Exam	niner: On the basis of	examination and/or i	investigation, in	he time, date and place, my opinion, death occur	red at the time,	date and place, and du	ue to the cause(s)
)	To T Com	≥ <	29b. Signature and title of certifier	Down	+	29c. Li	S667 Lutherville		September	7.8 2010
			30. Name and address of person who	completed caus of de	eath (Item 23a) (Type	a, Print)	1.41 11	~ M J	71407	00,0010
1	Sta	100	31. Date filed (Month, Day, Year)	32. Regist	r's Signature		Luinenu, Il	E, 170	C1013	
	Registr	ar		2010	nova B.	gark		-		

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** over Der 18 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hopkins 6. Sell 7 Hospita It more If Under 24 Hrs. Birthplace (State or Foreign Country) i, Day, **Funeral** 219-28-1382 1 M 2 F Months Days Hours Min. VIRGINA Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expriner must be notified at once. 10a, State 10h. County 10c. City, Town or Location Baltimore 1 TYes 2 No Funeral Director Rid 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Patteron &K USA NO 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No BLACK Specify Completed by 3 ₩idowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 ememaker one estic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be heoter 15199ERS Hines ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) // Pollaro DR Balto. Md. 21222 Cameron 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation Maryland Det 4 Donation 5 Dother (Specify) 21. Signatur / Funeral S Approximate Interval Between Onserand Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. espiratory arrest Immediate Cause (Final Physician schemic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 mon Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Janknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2. No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifies completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

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31. Date filed (Month, Day,

32. Regietrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Raymond

29c. License number

th WOIFE

29d. Date signed (Month, Day, Year)

		1	For State Registrar	State of Mar		artment of H rtificate of L		Reg	ene J. No. 2	30707			
	Physicia	n	Decedent's Name (First, Middle, La RUFUS		LIAMS J	ΠR.	S	2. Date of Death Month EPTEMBER	Day Year 5 2010	3. Time of Death 4:51 PM			
	/Medic Examin	-	4a. Facility Name (If not institution, giv			4b. City, Town, or			4c. County of Death				
			PRINCE GEORGE'S			CHEVERL			PRINCE GI				
	Funeral Director		240 30 3437	7. Age (1 X M 2 F 84	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 4/4/192		nplace (State or Foreign untry) umbia, SC			
	yland Iow at	-	Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or Lo	ocation				10d. Inside City Limits			
	a-f sh	ctor	DC		Washingt	on				1 XYes 2 No			
	or 28	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	untry?			
	ath w s 23a nust k	iral	5119 E Street S		110	200			USA 14. Race - Amer	ican Indian			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	귤	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1 2 Yes 2 □ No If Yes, Give Year or Dates: Wh		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2☐√No	ispanic Origin? (Spo an, Mexican, Puerto Specity:	Rican, etc.)	Black, White	e, etc.			
Ö	thours atural" cai Exa	ed b	3 □★Vidowed 4 □ Divorced 15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation	. 10	 6b. Kind of Business/I	Black			
21215-0036	vithin 72 nne. .han "na ne Media	Completed by	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	Labo	e kind of work done of DO NOT use retired	during most of work t)		Desirent				
Q Q	filed v Hygie sther 1	ပ္ပ	17. Father's Name (First, Middle, Las.)	Labo	rer	18. Mother's Name		Private aiden Surname)				
au	lid be lental ked o	To Be	Rufus Williams				Katie Day	vis					
ary	shou and M s mar umat	- 3	19a. Informant's Name/Relationship	Type. Print)	19b. Maili				City or Town, State, 2	Zip Code)			
Σ	and 2 ealth a n 27 is	lu-	Dorothy Kenlaw /	Daughter		E. Street							
ore	ges 1 t of H _i if iter or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other plac	ce)	Date 2	0c. Location - City or	Town, State			
Baltimore, Maryland	t. Pagrimen rtant: njury		4 □ Donation 5 □ Other (Special		Fort Lin				Brentwood,				
Ba	permil Depar Impor any ir		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747										
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ds, P	res tha igned be de	b	b	þ	by	DIABETES MELLITUS TYPE II							o the cause of death?
Record	law requii as been s 2 should	Completed	HYPERTENSION					24a. Was an		utopsy findings available			
Ä	o - e	mo:						autopsy perform	formed? death?				
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or Vital	Physician: this certific	2	1 ☐ Yes 2 【XNO	Hospital: 1 Inpatient			4 LI Nursing H		nce 6 Other (Spe	ecify)			
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	urs urs erai			hysician: To the best of									
	To the Hosp within 24 ho To the Fund completely f	Medical		miner: On the basis of e and manner state		investigation, in my	opinion, death occu	rred at the time, da	ate and place, and du	e to the cause(s)			
	To the within 2 To the complex	Ž	29b. Signature and title of certifier			29c. Licens		ļ	9d. Date signed (Mon	,			
			Me				036896	SE	PTEMBER 10) , 2010			
			30. Name up secress of person wh				TT TTACTITY	CTON DO	201.221600				
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		•	for State Registrar	Otato or maryiar	Certifica				Reg. No	3010	3.0708				
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	Ild be filed within Mental Hygiene. Iarked other tha Iatic event, the I	To Be C	17 Father's Name (First, Middle, Last)	- 51 +	lead	ne		ne (First, Middle	, Maiden S	ITU. CI Burname) Vens	ry JENOOLS				
, Maryland	and 2 should Health and Me tem 27 is marl ther traumati		$[1,1,1], \overline{D}$	wn/Broth		ress (Street d	and Number or Ru	ral Route Numb	er, City or	Town, State, Zi	ip Code)				
Baltimore,	Page 1 ment of ant: If it		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Disposition (I cometery, crematory of OCA A W	or other place	10-0	Date -2010		altimo	re, MD				
Bal	permit. Departr Imports any inji		21. Signature of Funeral Service Licensee	Sun	22. Name	and Addres	ss of Facility	Ighn C.		ne Fune stown. N	nn Services				
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of \	ng Phys ter this neral di	te: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	ER/Outpatient 3 28b. Time of injury	28c. Injury	y at	28d. Describe	how injury	occurred	cny)				
Division of Vital Records,	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director, After this completed filled in by the funeral di		Certificate:		2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	M ome, farm, street, fac	M 1 ☐ Yes 2 ☐ No m, street, factory, office 28f. Locatio			n (Street and Number or Rural Route Number, Town, State)		ural Route Number,		
	Hospital of 24 hours at Euneral Dieted filled i	Medical	(Check 2 Medical Examine	ian: To the best of my know	on and/or investigation	, in my opinio	on, death occurred	at the time, date	and place,	and due to the	cause(s) and manner stated.				
	To the within 2 To the comple	-	29b, Signature and title of certifier	Practioner: To the best of m		29c. License	e number		29d, Dat	e signed (Mont	th, Day, Year)				
2			30. Name and address of person who cor			v- S-	. 203,	Baltmor	e, r	10.21	209				
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrario Signa 2010		barke	9								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 28 2010 9:45p M <u>Ah-ii</u> Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard Ellicott City Health & Rehabilitation Ellicott City Social Security Number 8. Date of Birth (Month, Day, Ye March 28 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 Hours South Korea Director 101 1909 071-70-7446 Usual Residence of Deceden show 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No <u>Maryland</u> Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? South Korea 21043 3000 N. Ridge Road death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. "natural", or <u>م</u> 1 X Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 72 hours after Asian 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Ó Homemaker Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk Oh unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kisung Koh, Granddaughter 11163 Willow Green Way, Marriottsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State injury or 4 Donation 5 Other (Specify) Metro Crematory, Inc. 9/29/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Soular 9 Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending the individual. Cause (Disease or linjury the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetar dean
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) ate has been signed by the apage 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 Yes 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 3 Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral (27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 No within 24 hours after death

To the Funeral Director: A
completed filled in by the f Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) DA7683 MO

State Registrar

DHMH 17 Rev 7/2009

Ru

mera 31. Date filed (Month, Day, Year) 21209

Balance

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

South

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland		rtment of H <i>ificate of D</i>		and Mental Hy	2010	30710	
			Registrar 1. Decedent's Name (First, Middle, Last)	Cert	incate or D	catii	2. Date of De	Reg. No. C U L ath Day Year	3. Time of Death	
	Physician/ Medical Examiner		Susan Bozman Acree 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Leastion	Septembe	er 10 2010 11:12 PM M		
			Wicomico Nursing Home		Salisbu			4c. County of Death Wicomico		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last I 217-10-2020 1		If Under 1 Year Months Days	If Under : Hours	24 Hrs. 8. Date of Bir Min. 04/24/	th 9. Bit 1919 Ma	thplace (State or Foreign Punto) Land	
	ind show	'n	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Loca	ation				10d. Inside City Limits	
	Maryla 28a-f s otified	Director	4	isbury					1 X Yes 2 □ No	
	with the s 23a or ust be n	Funeral D	10e. Street and Number 717 Madison St.		10f. Zip Code 2180	4		10g. Citizen of What CoUSA	ountry?	
-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fun	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	lf'	as Decedent of His Yes, specify Cubar	n, Mexican	gin? (Specify Yes or No- , Puerto Rican, etc.)	Black, Whit		
5-5-5	72 hou n "natu ledical	nplet	(Specify only highest grade completed)	(Give ki	ent's Usual Occupa nd of work done do NOT use retired)	ition uring most	of working	16b. Kind of Business	Industry	
27.2	within giene. ner thai		Elementary/Seconday (0-12) College (1-4 or 5+)		visor			telephone	company	
1 and	be filed lental Hy rked ott	To Be	17. Father's Name (First, Middle, Last) Isaac D. Moore				er's Name <i>(First, Middle,</i> Cy Cooper	Maiden Surname)		
Maryland 21215	d 2 should alth and N 1 27 is ma er traumat		19a. Informant's Name/Relationship (Type, Print) John Bozman/son	19b Mailing 713 N	Address (Street a ladison S	nd Numbe	r or Rural Route Number Salisbury,	MD 21804 ate, Z	ip Code)	
SUS)	age 1 and ent of He nt: If item y or othe		1 Rurial 2 Cremation 3 Removal from State ceme	netery, crema	ition (Name of atory or other place Cremator		Date 9/15/2010	20c. Location - City o		
Saltiir	permit. P Departm Importar any injur		21. Signature of Juneral Service Licensee	_			al Home Pr	ofessional bury, MD 21	Association 804	
			23a. art 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	Oo not enter	the mode of dying				Approximate Interval Between Onset and Death	
	Physician/ Medical	9 1	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence)	(GN)	ENTI	A .		<u> </u>	Oriset and Death	
1.00	Examiner	ē	Sequentially list conditions, If any, leading to immediate Due to (or as a consequence)	ace of).			· · ·			
	uted Id ansit	amin	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events							
0	ate be executed physician and the burial-transit	dical Examiner	resulting in death) Last Due to (or as a consequence	ice of):						
68760	tificate ng phys as the	Medi	IF FEMALE:							
Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	leath 3 🗌	Ectopic pregnancy Other (specify)	<i>y</i>		23d. Date of de Month	elivery Day Year	
'ds, P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting	ing in the un	derlying cause give	en in Part I			Probably 4 Unknown	
Division of Vital Records,	The law re ate has be page 2 sh	Completed by		-			24a. Was auto perfi 1 \square Yes	psy prior to death?		
/ital	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER.	2/Outnations	Othe	r /	th (Check only one)	idence 6 Other (Spe	cifu)	
n of V	iding Phy. th. After this funeral d	cate: To	TE inpatient 2 E En	Bb. Time of injury	28c. Injury work?	at	28d. Describe	how injury occurred	City	
ivisio	or Attendi after death Director, A in by the fi	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, stree	et, factory, office		28f. Location (City or To	Street and Number or Ri wn, State)	ural Route Number,	
Ω	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2.	Medical	29a. Certifier (Check only one) 3 ☐ Certifying Physician: To the best of my knowledged only one) 3 ☐ Certifying Nurse Practioner: To the best of my kn	nd/or investig	gation, in my opinio	n, death oc	curred at the time, date	and place, and due to the	cause(s) and manner stated.	
	To th Vithii COTE		29b. Signature and title of certifier	-	29c. License	number	C	29d. Date signed (Mon. 9//3///	th, Day, Year)	
	Sy		30. Name and address of person who completed cause of death (item 23 Mahesha Thimmarayappa M.D. 910 Easte		int) e Dr Salis	shurr	MD 21804	1 - 2 // 4		
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 5 2010 32. Rigistrar's Signature		DI Sails	our y	ED 21004			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 08:15AM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Harwood Mandrin House Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 M 2 W Months Days Hours Min Month Day, Year) 929 Country) Aug Ohio Director 206-22-7268 81 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Merical Examiner must be notified at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Virginia Hancock Weirton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26062 United States 408 Mildred Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 and Mental Hygiene. is marked other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Healthcare Nursing Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H 2 Adolphine Marie Walter James Rattigan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 si Health a Rita L. Kolberg/daughter 5639 Aiken Road McKees Rocks, Pennsylvania 15136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 and Department of H Important; If it any injury or o ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 9/17/2010 Woodbine, Maryland . Sign Rure of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 - M00957 thomas 23a. Par 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Panc rea disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Inter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page rmed? 2 X 1 ☐ Yes 2 ☐ No 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No 4 Nursing Home 5 Residence 6 Mother (Specify) MANDRIN ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of TOUSE 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 5 Pending work? Division To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completed filled in by the fu 2 🗌 No after death Accident Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 1

DHMH 17 Rev 7/2009

State Registrar egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 <u> 10:30</u> John Francis Babick September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick 7689 Anvil Drive 8. Date of Birth 9. Birthplace (State or Fore Country)

March 12, 1956 West Virginia Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Days Months Hours Min. Director 234-88-2947 54 Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō permit. Page 1 and 2 should be filed within 72 hours after death with th Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. Funeral United States 21701 7689 Anvil Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black. White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Network Engineer Computer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bays Boyd William Babick Dolores Jean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7689 Anvil Drive Frederick, Maryland 21701 Carole Suzanne Babick/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 9/17/2010 Woodbine, Maryland ure of Funeral Service Licensee 21. Sig Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD uanita M00957 thomas 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PANCREATIC CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 a ending IF FEMALE detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year 4 Pregnant : 9 Unknown Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 ☐ No the Division of Vital Records, P.O. completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy death? 2× No 1 🗌 Yes Yes 2 Z Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) SEPTEMBER 15, 2010 70062100 M.D

State Registrar DUNG LC

10

Barks

ORLEAMS STREET, ROOM 407 BACTIMORE, MARYLAND

2123/

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 307 I Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician J. Robin Bosting1 Sept. 15, 2:38P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George Ft. Washington Hospital
5. Social Security Number 6. Sex Ft. Washington 8. Date of Birth (Month, Day, You Jan. 10, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Year) Months Days Hours 1966 California 44 548-15-1722 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c City Town or Location s 23a or 28a-f show 10a State 10b. County 10d. Inside City Limits Funeral Director 1 X Yes 2 □ No Maryland Prince George Forest Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 143 South Huron Drive 20745 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items any injury or other traumatic event, the Medical Exercitivator. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify. <u>\$</u> Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edith F. Diamond Fred A. Stout ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9786 Floyd Lane, San Angelo, Texas 76901 Fred A. Stout/Father Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kalas Crematory 9/17/2010 |Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home an 6160 Oxon Hill Rd. Oxon Hill, MD 20745 23a. Parta. Enter the disease, or complications shock, or heart failure. List only one cause hat caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-trar resulting in death) Last Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No. g 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 □ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No □Ýes 2 **X** No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 1□Yes 2**2**No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature and title of certife 29d. Date signed (Month, Day, Year) 46046 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amir Mirza Alikhani, M.D. 11711 Livingston Road, Ft. Washington, MD 20744 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 7 2010 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month John Anthony Clifford September 2010 4:50 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery Date of bill (Month, Day, 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Days Hours 1 🔀 M 2 🗆 F 215-26-2877 78 **Director** Jan. Washington, D.C Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Damascus 1 🗌 Yes 2 🗙 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10320 Bethesda Church Road 20872 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 195
If Yes, Give 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 2 □ No 1956-Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: Specify: 3 Divorced 4 Divorced 1959 White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Corporate Training Amtrak Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Pau1 Clifford Julia Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 10320 Bethesda Church Rd., Damascus, Md. 20872 Virginia A. Clifford / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Metropolitan Crem. 9/13/10 4 Donation 5 Other (Specify) Alexandria, Virginia 22. Name and Address of Facility
Muriel H. Barber Funeral Home Signature of Funeral Service Licer 0 Box 5038, <u>Laytonsville</u> 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition METHSTATUL BRION 1 MENUTH Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Examiner Due to (or as a consequence of) igned by the attending physician and be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months? Month Day Year 2 No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? UBSTRUCTUE NUMONTES DUENE 24a. Was an autopsy performed' 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at work? 1 ☐ Yes 2 ☐ No Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) | Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death assumed to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15+1UA THURON, MD 04m wood 3416 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State	of Marylan				and M	ental Hy	giene	010	20715	
	Registrar Ce						rtificate of Death Reg. No.					30/13	
	Physicia	in/	1. Decedent's Name (First, Middle, Last)	Lewis Collins			2.				Year	3. Time of Death	
	Medic	al	Marion Lewis					ptember 21, 2010 1:35 a					
) Examin	er	4a. Facility Name (if not institution, give street and r			4b. City, Town,		of Death			County of Death	_	
	F		Hospice House of St. 5. Social Security Number 6. Sex	Mary's 7. Age (In yrs. Ia	est hirthday	Call If Under 1 Yea	away_	r 24 Hre	8. Date of Birt		St. Mary		
	Funeral Director	Н	5. Social Security Number 6. Sex 1 M 2 \square	F 85	Yrs.	Months Days			(Month, Day 07 / 23 /		Cou	hplace (State or Foreign intry) ⊇ inia	
			Usual Residence of Decedent					1	011231.	1923	IVIL	ZIIII a	
	sho dat	ţō	10a. State 10b. County	10c. City	y, Town or Loc	cation						10d. Inside City Limits	
	Mary 28a-1 otifie	Director	Maryland St. Mary's	Mecl	nanics	ville						1 🗆 Yes 2 ី No	
	n the aor ben		10e. Street and Number			10f. Zip Code				10g. Citiz	zen of What Cou	untry?	
	h witl ns 23 nust	Funeral	27291 Budds Creek Road			20659				Unit	ed Stat	tes	
	deat riten inerr		11. Marital Status 12. Was D	ecedent Ever in U.S Forces? es 2 🔼 No	5. 13. V	Vas Decedent of Yes, specify Cub	Hispanic Or pan, Mexica	rigin? (Spec an, Puerto R	cify Yes or No- Rican, etc.)	1	 Race - Amer Black, White 		
36	after al", o	d by	If Yes,	Give	1	☐ Yes 2 🗓 N	o Specify	<i>/</i> :		s	Specify:		
8	atura cal E	Completed	3 Uvidowed 4 Univorced Year or Year or 15. Decedent's Education	Dates.	16a Deced	ent's Usual Occu	nation	_	1	105 1/3-	White b. Kind of Business Industry		
15	. 72 h	JG III	(Specify only highest grade complet		(Give F	rind of work done NOT use retired	during mos	st of workin	g	IOD. KIN	id of Business i	ndustry	
212	withir giene er tha the		Elementary/Seconday (0-12) College	(1-4 or 5+)		tor Mech	,			Elev	ator Co	onstructors	
b	illed y	Be	17. Father's Name (First, Middle, Last)					her's Name	(First, Middle,				
/lar	d be d Aenta arked tic e	은	Otto Harrison Collins				Beat	trice	Triffi	ania	Lewis		
Maryland 21215-0036	2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " traumatic event, the Med	, y	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Stree	t and Numb	er or Rural	Route Number	; City or T	Fown, State, Zip	Code)	
	nd 2 salth n 27 er tra		Mary Aline Collins/Wif	e	27291	Budds C	reek	Road,	Mechar	nicsv	ville, N	4D 20659	
ore	of Her		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal fr		lace of Dispo	sition (Name of natory or other pla	- :		ate		cation - City or		
<u>Ĕ</u>	Page ment ant: I	l i	4 ☐ Donation 5 ☐ Other (Specify)	Jill Clate			· ·	09/22	/2010	Char	·lotte E	Hall, MD	
Baftimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign Jure et Funeral Service Licensee)		Name and Addr							
ш	205 # 9		Edward N. Brinsfield.	Jr. M00	052 3	<u>0195 Thr</u>	ee No	otch R	d., Ch	<u>ar1ot</u>	tte Hal	1, MD 20622	
			23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on	at caused the death each line.	. Do not ente	r the mode of dy	ing, such as	s cardiac or	respiratory arm	est,		Approximate Interval Between	
	hysician/	8 7	Immediate Cause (Final disease or condition	poart	east Failure				1	Onset and Death			
	Medical Examiner		resulting in death) Due	to (or as a consequ	ence of):								
		ē	Sequentially list conditions, b.	OTHER P									
		Examiner	cause. Enter Underlying Cause (Disease or iinjury	อกตั <i>ง</i> บไ):						- 1			
	and and Il-trar	Еха	that initiated events C. ———	ence of):									
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P,O, Box 687	es that the des signed by the a be detached t	Physician/Me	9 🗆 ORKHOWN	☐ Unknown				_					
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CO	aw re las be	Completed							24a. Was a autop		prior to co	opsy findings available ompletion of cause of	
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ta	cian: ertific ector,	Be	25. Was case referred to medical examiner?				Place of Dea	ath (Check o	only one)		46	Hospice	
Ξ	Physi this c	<u>۵</u>	1 Yes 2 No	Inpatient 2 1	ER/Outpatien 28b. Time of	1 3 L DOA					Other (Specif	_{fy)} House	
0 0	ding l h. After funer	Certificate:	↑ Natural 5 ☐ Pending (M	onth, Day, Year)	injury	28c. Inju wor M 1 [ryat rk? ∐Yes 2.⊑		Bd. Describe ho	ow injury o	occurred		
Sio	dest ctor y the	tific	2 Accident Investigation 3 Suicide 6 Could not be	ce of Injury - At hor	me farm stre			$\overline{}$	of Location (St	troot and	Number or Pur	al Route Number.	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours a er desth. To the Funeral Director After this certificate has been signed by the completed filled by the funeral director, page 2 should be detached.			Iding, etc. (Specify)		,,,		-	City or Town		ivarriber of riare	ar noute rumber,	
	spita hours neral	ical	29a. Certifier 1 Certifying Physician: To the	e best of my knowle	edge, death o	ccured at the tim	e, date and	place, and	due to the cau	ise(s) and	manner as stat	red.	
	ne Ho n 24 l	Medical	(Check 2 Medical Examiner: On the long one) 3 Certifying Nurse Practione	pasis of examination	and/or investi	gation, in my opin	ion, death o	ccurred at the	he time, date ar	nd place, a	and due to the ca	ause(s) and manner stated.	
	Nithi To th		29b. Signature and title of certifier	1)		29c. Licens	se number				signed (Month,		
	,		► CMMO H0055751 9-21-10									0	
me	_		30. Name and address of person who completed ca	,		,							
11~			Jennifer Schmidt			ts Lane,	Leon	ardto	wn, MD	2065	50		
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	negistra		SEP 2 2 2010 🔏	mour p	. La ar	ne -							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Callis 5:30 p.M Pear1 Hemby September 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's 25155 Sotterley Road Hollywood 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. 08/27/1925 North Carolina **Director** 85 246-26-3066 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director St. Mary's Hollywood 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 20636 25155 Sotterley Road hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 K No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify Completed 3 Midowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Meat Department Grocery Store 11 it. Page 1 and 2 should be filed w rtment of Health and Mental Hygi rtant: If item 27 is marked other njury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Howell Eugenia В. Hemby James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tricia Callis/Granddaughter 25155 Sotterley Road, Hollywood, MD 20636 20a. Method of Disposition permit. Page 1 a
Department of F
Important: If ite
any injury or oth 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Joy Chapel Cemetery 09/25/2010 Hollywood, MD 21. Sign so Spring Sensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Rd., Leonardtown, MD 20650 Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Comme ARRY THWAS. Ph_sician/ Medical Due to (or as a consequence of): Examiner YEARS. CARDIONY OPATHY 1 CCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated experts. Examine Due to (or as a consequence of,: CO RON ARY AR TORY Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 Pregnant a 5 Other (specify) Day Year Pregnant at time of death signed by the a Id be detached f 1 ☐ Yes 2 € 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HIDERTENSON 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed BRIGAST CANCER 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy this certificate Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 □ Yes 2 □ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After iniury 1 Natural 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu after death. Director: Af 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar only one)

29b. Signature and tile of certifier

RADINDER MAM 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

ASSOCIATES

29d. Date signed (Month. Day, Year) 9-22-10

MOLLYWOOD)

20836.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month September I6, 2ÖÎO **JANIE** LEE CONNER 10:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harley Hall Nursing Home Pocomoke City Worcester Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months Days Min 12/30/192 Director 214-12-6500 88 Mary Land Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maryland Somerset Marion Station 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21838 28249 Old Crisfield-Marion Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black White etc. þ 1 Never Married 2 Married ☐Yes 21⁄2 No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. permit. Page 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the M Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker At Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Andrew Jackson Coons Virginia Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley L. Conner (Son) 28249 Crisfield-Marion Rd.-Marion Station, MD 21838 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State St. Pauls Cemetery 09/21/2010 4 ☐ Donation 5 ☐ Other (Specify) Marion Station, MD 21. Signatur Funer Service Licensus Robert H. Bradshaw 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ asc Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has I completed filled in by the funeral director, page 2 performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director, 6 Could not be 3 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractioner: To the est of the cause (Check

State

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within 2 To the F

Registrar

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ARAD Name and address of person who completed cause of death (Item 231) (Type, Print)

32. Registrar's Signature

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink / Ensure All Copies Are Legible.
Amend 23a per med cert G908 110 / Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1-0 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year CHURCH 2010 MARL CATHERINE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SNITSBUNG RICHMOND WICOMICO If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2**X**F CAROLINE 214-32-0525 76 Counts Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 🌠 No Director SALISBURY WICOMICO $m_{\rm D}$ 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or r must be r 21801 ICHMOND 4514 Funeral filed within 72 hours after death r than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ≰ If Yes, Give Year or Dates: 2**X** No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) UPPRUZEOR SPRUKE ENVIRONMental .. Pages 1 and 2 should be filed wi trnent of Health and Mental Hygier tant: If item 27 is marked other th jury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be moson 40/00 JOHN THOMAS 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Place of Disposition (Name of cemetery, crematory or other place) KORD LINTHIA IMOSON 20a. Method of Disposition Date 20c. Location City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Klen STEWANT Ferranz L Home 23a. Part1. Enter the disease, or conditiations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURA **Physician** RRNAL CHRONIC ili /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 paorths? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 ☐ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1∐ Yes 2∰No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an certificate has autopsy 1∐ Yes Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Scher (Specify) Hospice 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Hospital or Attending Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated.

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Maryland 21215-0036

Baltimore,

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Records,

Vital

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Division

State Registrar 29b. Signature and title of certifier

CHUMAM

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WAR

DU

BOX

32. Registrar's Signature

DHMH 17 Rev 1/2001

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varked

29c. License number

DO05 8410

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene amend #12819a Per INF G918 8717/2011 JH

Certificate of Death

Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 9 2010 Bert Collison Physician/ Arnold Month Sentember Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Memonal Hospital at Easton Talbot If Under 24 Hrs. 8. Date of Birth **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 **X** M 2 □ F Months Min 09/21/1920 89 213-20-8710 New Jersey Director Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No Maryland Talbot St. Michaels 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7047 Pea Neck Road 21663 USA 12. Was Decedent Ever in U.S. Armed Forces? 1942-46 127/es 281-No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. ARMY Specify: 3 Divorced 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) attorney law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles H. Collison Erna Fismer 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Nymber or Rural Route Nymber, City or Town, State, Zip Code, 7047 Pea Neck Rd., St. Michaels, MD 21663 Mary_Collison/spouse Mary Ruth Collison/spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 9/13/2010 Salisbury Crematory Salisbury, MD 4 Donation 5 Other (Specify) Jognature Funeral Solice of Insee 24611300 Ayes Puneral Home, Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one ca Immediate Cause (Final Priysician/ disease or condition resulting in death) ena 0 Medical Due to (or as a consequence of): Examiner 22 d Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Yes signed by the a 9 Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed Yes 2 X After this certificate funeral director, pag 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo ပ 1 💢 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af Accident 1 Yes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my spinion death. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gettifying Nurse Pranticiper: To the basis of my in called a first control of the time, date and place, and due to the cause(s) and manner as stated. (Check unly one) 29b. Signature and title of contific 29c. License number 29d. Date signed (Month, Day, Year) D54488 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Easton, MD 21601 Washington St, 50 MD 219 Bennett 31. Date filed (Month, Pal, Year) 32. Registrar's Signatur State Registrar

Please Type or Printin Black Indelibie Ink. Ensure All Copies Are Legible.

Collison.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 30720 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month R Duckworth Raymond Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death WMHS-RMC Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)

WV 8. Date of Birth **Funeral** 1 🖵 M 2 🗆 F Months Days Hours Min (Month, Day, Aug 7 Director 213-12-9131 90 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany 1 ☐ **X**es 2 ☐ No Oldtown 10e. Street and Number 10f Zin Code 10g, Citizen of What Country? Funeral items 23a 17525 Oldtown Road, S.E. 21555 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 9 Black, White, etc. Completed by 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours aft nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Specify other traumatic event, the Medical white 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Glass Industries Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Mathias Tice Duckworth Bessie (Kenney) Duckworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Decartment of Health Important: If item 2 any injury or other 1 <u>Vivian Duckworth</u> Wife 17525 Oldtown Road Oldtown MD 21555 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 9/30/2010 Davis Memorial Cemetery MD Cumberland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) neumonia Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or iinjury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 🗆 Yes 2 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24a, Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy death? 2 🗌 No 1 🗌 Yes Yes 2 2 N 25. Was case referred to predical completed filled in by the funeral director, æ 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury accurred Natural 5 Pending work Accider
Suicide Accident Investigation 1 Yes 2 🗌 No 24 hours after deatl 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the I only one 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie Date signed (Month, Day, Year) use of death (Item 23a) (Type, Print) 30. Name and address of person who completed Gary Wagoner M e filed (Month, Day, Year) 925 Bishop Walsh Drive Cumberland MD 21502

DHMH 17 Rev 7/2009

State

Registrar

32. Regist

r's Signature

10-07174 Melanie Anne Davis

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State of Maryland / Department of Health and Mental Hygiene	201	U	0.0	1 6	۵

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Funeral Director	5. Social Security 531–15–6	120	ex 7. Age	(In yrs. last bi	rthday) Yrs.	If Under 1 Yes		1.00	3. Date of Birt	h(мм/DD/YYYY 1983	9. Birth Foreign Cou	Nebraska
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director										ber, City or Towr E 68788	ı, State, i	Zip Code)
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1			completed cause of de		or 111	Penn Stree	at Raltim	ore MD	21201			
State		Southall, MD	3 Registrar				., Daillill	- NID	£1201			
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Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DiPreta 6:40 Pp M Margaret Ann September 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town or Location of Death 4c. County of Death Hospice House of St. Mary's St. Mary's Callaway 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpu Country) York **Funeral** 1 M 2 X F Months Days Hours Min. (Month, Day, Year) 05/28/1945 Director 072-38-3406 6.5 New Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertial Hygiene.

Timportant If item 27 is marked alther than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22864 Thornbury Drive 20636 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. by 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Academic Coordinator Harry Lundeberg School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Albert Fischer Margaret Heeb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerard DiPreta/Husband 22864 Thornbury Drive, Hollywood, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Immaculate Heart of Mary Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/22/2010 Lexington Park, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield M00052 22955 Hollywood Road, Leonardtown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Orset and Death Immediate Cause (Final Physician east disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 1 🗌 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospice Other: 1 🔲 Yes 2**X** No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
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10 1

DHMH 17 Rev 7/2009

State

Registrar

William D.

31. Date filed (Month, Day, Year)

Boyd,

SEP 21

II M.D.

25365 Point Lookout Road, Leonardtown, MD

10-07243 Jack Lee Davis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ICK LEE DAVIS		State of Maryland / Department of He Certificate of De			2UIU	30123
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
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			ity, Town, or Location of Deatl ederick	ו	4c. County of Death Frederick	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If I	Under 1 Year If Under 24Hr	s. 8. Date of Birth	n(MM/DD/YYYY) 9. Birt	
Director		214-88-4621 1X M 2 F 47 Yrs.	onths Days Hours Mir	May 27	, 1963 Foreig	n untryMary1and
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygier Important: If item 27 is marked other than injury or other traumatic event, the Medica			and Address of Facility &			
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/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. $Alcohol$ and morphine in	ntoxication			Death
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ViSiC or Atte ter dea trecton n by th	ficat	Accident Accident Accident Suicide Accident Could not be Accident Could not be Accident Accident Suicide Accident Could not be	tory, office building, etc.	28f. Location (St	reet and Number or Run	ral Route Number, City
Divis Hospital or At 24 hours after d Funeral Direct	Certification:	4 Homicide determined (Specify) found in parkin	g lot	Frederic		————
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at cone 2 Medical Examiner: On the basis of examination and/or investigation, in				
To To	Me	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)
		(and Hallan	O.C.M.E.		September 21, 20	010
		Name and address of person who completed cause of death (Item 23a) Carol Allan, MD	et, Baltimore, MD 2120	1		
	ate		<u> </u>	-		
Regis	_	31. Date filed (Month, Day, Year) 2010 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day Year Evalee Y. Dryden 3:56 AM M Sept 2010 16 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hartley Hall Nursing Home Worcester Pocomoke City 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days Hours Min. (Month, Day, Year) Maryland Director 221-14-3378 87 Mar. Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Medical Examiner must be notified at Director 1 Yes 2 No Md. Worcester Pocomoke City 10e, Street and Number 10g. Citizen of What Country? Funeral items 23a 1006 Market Street US 21851 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 ģ 1 Newer Married 2 Married If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Russell Young Eleanor Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1214 Cedar Hall Road, Pocomoke City, Md. 21851 Mrs. Suzanne Nelson, Daughter 20a. Method Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beechwood Cemetery 09/19/10 Princess Anne, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home, PA M00295 11673 Somerset Ave, Princess Anne, Md. 21853 art 1. Enter the disease, or complications and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death mediate Cause (Final Physician/ ATHEROSCLEROTIC CARDIOVASCULAR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of, Exami that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No fo Year Day Pregnant at time of death signed by the a g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined

Box 68760 P.0. Records, Division of Vital

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law completed To the I within 2

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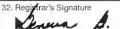
29a, Certifier

(Check

29b. Signature and title of certified

R SATYAL 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



MI)

🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

10062172

1604 MARKET ST. POLOMOKE CITY MD 21851

29d. Date signed (Month, Day, Year)

29c. License number

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Seatember 25 Harold Francis Eccleston 2010 7:05 Pм 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Date of Birui (Month, Day, Year) 1944 9. Birthplace (State or Foreign 8. Date of Birth 1 X M 2 □ F Months Hours Min 66 New York 060-34-6078 June Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 X No Frederick Maryland | Frederick 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21703 United States 5319 Stone Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black White etc. 1 Never Married 2 X Married 2 X No Yes If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) United States Navy Chemist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jane Pisano Harold F. Eccleston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5319 Stone Road, Frederick, Maryland 21703 Beverly | Magyar / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Septémber 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mount Olivet Cemetery 28 2010 Frederick. Maryland of Funeral Service License ^{22. Name and Address of Facility} Keeney and Basford PA Funeral Home 106 East Church St. Frederick, Mar MO1473 Marvland implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final Onset and Death rostet Cancey disease or condition resulting in death) Due to (or as a consequence of):

Physician/ Medical Examiner

attending physician and for use as the burial-transit

signed by the a d be detached for

certificate has

within 24 hours after death.

To the Funeral Director: After this

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

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ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

and Mental Hygiene. is marked other than

permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic any in.

traumatic

be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical Examiner Completed by

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Repiratory Defression Due to (or as a consequence of): d			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of deliv Month	rery Day Year
Part II. Other significant conditio	ns contributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the	he cause of death?
		24a. Was an autopsy performed?	prior to co	ppsy findings available ompletion of cause of

25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify, 1 🗀 Yes 2 🔽 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 2 🗆 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Day, Year) Doo 6 9963

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 West Seventh Street, Frederick, MD 2170

State Registrar

SANDHYA 31. Date filed (Month, Day Regist s Signatu

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DHMH 17 Rev 1/

			Pieas	e Type or Pr					Mental Hyg	_	ie.
		For State		State of	viai yiai		rtificate of			eg. No.201	0 30726
		Registrar 1. Decedent's Name	(First, Middle,	Last)			- Inouto or		2. Date of Dea	h	3. Time of Death
Physicia		EDWAR	D ELL	JIS					SEPT.	8, Day 2010	9:45AM M
/Medica Examina	-		not institution, g	give street and number	er)			or Location of Dea	ath	4c. County of	f Death
Funeral		5. Social Security N		5. Sex 7.	Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hr	S. 8. Date of Birth		9. Birthplace (State or Foreign
Director	-	578 42 Usual Residence of		1 ⊠ M 2□F	88	9 Yrs.	Months Days	Hours Mir	MAY 9,	1922	WASH. DC
yland how		10a. State	10b. County		10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
e Mar	ç	MD.	P.G	· .	7	rempl:	E HILL	S			1 XYes 2 No
filed within 72 hours after death with the Maryland Hyglene. other than "natural", or items 23a or 28a-f show ent, the Medical Exprimer roust be notified at	Funeral Director	10e. Street and Nun 4205 1		VENUE			10f. Zip Code	748	1	0g. Citizen of Wr	nat Country?
ns 23	era	11. Marital Status		12. Was Decede	nt Ever in U.	S. 13.			(Specify Yes or No- erto Rican, etc.)		- American Indian,
or iten		1 Never Marrie	ed 2 Marrie	Armed Force d 1 ☐ Yes 2 [s?	- 1			erto Rican, etc.)		, White, etc.
ural", c	d b	3 Widowed	4 Divorced	If Yes, Give Year or Date	S:		1 □Yes 2 X No				BLACK
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s 1 and the Heal		20a. Method of Disp		,, - 112 2112	20b. F	I	psition (Name of patery or other pla		Date		City or Town, State
Pages nent o int: If i			Cremation 3 5 ☐ Other (Spe	I □ Removal from Sta ecify)	te RÍ	VERDA CREMA	LE PARK TORY	9/1	11/10	RIVERD	ALE, MD.
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, I'm Medical once.		21. Signature of Fu	neral Service Lic	censee		2:	2. Name and Addr		5 14th S	T.,N.W	-20010 . WASH. DC
		23a. Part 1. Inter th	ne disease, or cr	omplications that caus	sed the deat	h. Do not en	ter the mode of dy	ng, such as cardi	iac or respiratory ar	est,	Approximate Interval Between
Physician		Immediate Cause (Final	nly one cause on each		NCER I	WITH BR	AIN MET	CASTASIS		Onset and Death
/Medical Examiner		resulting in death)	•	Due to (or	as a conseq	uence of):					
	<u>_</u>	Sequentially list cor	nditions,	b	as a conseq	uerce et i					
uted d ansit	Examiner	Sequentially list con daily, leading to find cause. Enter Under Cause (Disease or that initiated events	rlying injury	200 10 (0.							
		resulting in death) L	ast	Due to (or	as a conseq	uence of):					
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eath certificate attending physic	Physician/Medi	IF FEMALE:		23c. If yes, outcor	ne of pregna	ancy				23d Date	of delivery
death e atter d for u	iciar	23b. Was decedent in the past 12 1 Yes 2	months?	1 ☐ Live birt 4 ☐ Pregnar	h 2 ☐ Feta it at time of d	Ideath 3	☐ Ectopic pregnan ☐ Other (specify)	су		Mon	
at the by the	hys	9 ☐ Unknown	1110	9 ☐ Unknow	n						
res the	ই	Part II. Other signif	cant condition	s contributing to deat	n but not res	ulting in the u	nderlying cause gi	ven in Part I.			bute to the cause of death? 3 ☒ Probably 4 ☐ Unknown
w requ	Completed								24a. Was a	n 24b. W	Vere autopsy findings available
The law te has age 2 s	d mo								 autop: perfor 	sy pr med? de	rior to completion of cause of eath? □Yes 2□No
	ğ Be	25. Was case referr	ed to medical					26. Place of D	1 ☐ Yes eath (Check only or		1168 2 1100
\$ \frac{1}{2} \frac{1}{2}	၉	examiner? 1 ☐ Yes 2 🛣				· · · · · ·	nt 3 🗆 DOA		Home 5 ☐ Resid		
ng F	ë	27. Manner of Death 1 □\text{Vatural}	5 Pending		njury <i>Day, Year)</i>	28b. Time o Injury	Wo	ıryat rk?]Yes 2 ∐No	28d. Describe h	ow injury occurre	d
death ctor: y the	licat	2 ☐ Accident 3 ☐ Suicide	investigat 6	t be	Injury - At h	ome, farm, st	reet, factory, office	ites ZLINO	28f. Location (S	treet and Numbe	r or Rural Route Number,
al or / s after al Dire	Certification:	4 Homicide	determin	building,	etc. (Specia	fy)			City or Tow	n, State)	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one)		Physician: To the be xaminer: On the basi and manner	s of examina						nner as stated. nd due to the cause(s)
To the within To the comple	Š	29b. Signature and	title of certifier					se number			(Month, Day, Year)
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8		30. Name and address	es of person wi	ho completed cause of	of death (Iter	m 23a) (Type,	Print)				
()		31. Date filed (Mont	ribn Day, Year)	32. Reg	strar's Signa	ature	ERN AVE	S.E.W	ASHINGTO	DN, D.	C. 20032
Stat Registra		SEP 1		Beneat	B. A	ares					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year 5:20 P™ Carrie Susie Franklin September 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death St. Mary's Hospital

5. Social Security Number | 6. Sex St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days 1 □ M 2 🖾 F 67 Yrs. Florida 263**-**71-9235 May 29, 1943 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 🖾 No St. Mary's Lexington Park Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20653 47061 Sorrel Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛂 No Specify: Specify: Black 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dan Robinson Lela Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48070 Windward Circle, Lexington Park, MD 20653 James C. Franklin / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition September 25, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 Ocala, Florida 4 ☐ Donation 5 ☐ Other (Specify) Ramah Cemetery 21. Signature of Funeral Service Vicensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Juliael P.O. Box 270, Leonardtown, MD 20650 × Jardiner Approximate Interval Between Onset and Death 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardiac Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): - (Metastatic) cast Cance Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 mor Year Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? ELiver Metastasis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy tonsian performed 2 🗆 No 2 No 1 □Yes 1 ☐ Yes 26. Place of Death (Check only one) Hospital: 2 No

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar O. Box 68760, Vital Records, Division of this

Physician/Medical Completed by Be Certification: To

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Registrar

Examine

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10a. State

Director

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Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Experiment on a colline of an

Department of Health ar Important: If item 27 is any Injury or other trau

Physician

/ /Medical

Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dientet 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number rickliq uIMO. JERNIST

DE 62123

29d. Date signed (Month, Day, Year) 09/16/2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shahid Rafat Siddiqui, MD. 25500 Point Lookout Road, Leonardtown, MD 20650

31. Date filed (Month, Day, Year)

20



Please Type or Print in Black Indelible hale / Finsure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O^{Pay} David J. Glen 20°1°0 11:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Months Days Hours Min. 09^M978 Pay 937 162- 42- 6412 58 Pennsylvania Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 9 10f. Zip Code 10g, Citizen of What Country? or than "natural", or items 23a on the Medical Examiner must be Funeral 4303 Fern Hill Road USA 20906 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 12 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 💢 No Specify: white Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Engineer Transportation Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೨ Donald J. Glen Margareta A. Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George S. Glen 5645 Greenvillage Road, Chambersburg, PA. 17201 Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🏋 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-9-2010 Chambersburg, PA Norland Cemetery 21. Signature of Funeral Service Lines Service 22. Name and Address of Facility Thomas L. Geisel Funeral Home M01346 Falling Spring Rd., Chambersburg, PA 17202 🗝 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Physician/Medical as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examirer? 1 LXYes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes within 24 hours after death

To the Funeral Director: / Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D63639 2011

DHMH 17 Rev 7/2009

State Registrar 1500 Frest Glen Road, Silver Spring MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEGABRYRN

POTU UR ATU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 0 | 0 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September Day 10, 2010 12:30a M Byron J. Greene Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick New Market 5712 Meyer Avenue 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 ፟፟ M 2 □ F Months Days Hours Min. Year) 1949 North Carolina Yrs Director 243-82-7057 61 Usual Residence of Decedent show 10b. County 10c. City, Town or Location death with the Maryland 10a. State 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 K No Frederick New Market Maryland 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral United States 21774 5712 Meyer Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗌 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1971–91 1 ☐ Yes 2X No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working nd Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ U. S. Army Major Be item 27 is marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 2 Page 1 and 2 should be I ment of Health and Ments Byron J. Greene Sr. Margaret Becton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5712 Meyer Avenue, New Market, Maryland 21774 Mary C. Greene / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, 1 X Burial 2 Cremation 3 Removal from State Crownsville Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Maryland Stauffer Funeral 1621 Opossumtown Homes Pike, P. A. Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death Immediate Cause (Final ₽hysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes မ 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 4 \(\sum \) Nursing Home Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined 24 hours a Funeral D Medical 29a. Certifier 😂 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and 29c, License number 29d. Date signed (Month, Day, Year)

18+1 UA

State Registrar Martin

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

30. Name and addyles of person the completed cause of death (Item 23a) (Type, Print)

Edelman MD,

22

32. Registrar's Signature

British.

D55065

South Greene Street, Baltimore, Maryland 21201

September 13, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar			epartment of He Certificate of De			eg. No.	0 30730
	Physicia	n/	Decedent's Name (First, Middle					Date of Death Month	h Day	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution	Toel Gerstin n, give street and number)		4b. City, Town, or Lo	ocation of Death	Septemb	er 13,	2010 11:00A M
	/		5600 Wisconsin			Chevy			Mon	tgomery
	Funeral Director		5. Social Security Number 578–14–3690	6. Sex 7. Agr 1 🕱 M 2 □ F	e (In yrs. last birthda 87 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 21	Year) 1923	9. Birthplace (State or Foreign Country) Washington, DC
	ind show at	'n	Usual Residence of Decedent 10a. State 10b. County	/	10c. City, Town or	Location				10d. Inside City Limits
	Maryla 28a-f s	Director	Maryland Mont	gomery	Ch.	evy Chase				1 ☐ Yes 2 🔀 No
	a or 2 be no	al Di	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	nat Country?
	ath wit	Funeral	5600 Wisconsin			20815		-i6 . V N		States
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status1 ☐ Never Married 2 ☑ Mar3 ☐ Widowed 4 ☐ Divorced	If Van Cive		 Was Decedent of Hisp If Yes, specify Cuban, Yes 2 No 	Mexican, Puerto I	city Yes or No- Rican, etc.)		- American Indian, White, etc. White
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ام 2	filed w al Hygi I other vent, t	Be	17. Father's Name (First, Middle,		I	Owner 1	8. Mother's Name			ng/Advertising
ylar	ld be 1 Menta arked atic e	욘	Jacob G	erstin			Mary			(unk)
Mar	Shou hand 7 is m traum		19a. Informant's Name/Relations			ailing Address (Street and			-	
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E	Page 1 nent of int: If		1 ☐ Burial 2 🙀 Cremation 4 ☐ Donation 5 ☐ Other 6	3 ☐ Removal from State Specify)	cemetery, o	crematory or other place) urney Crema	1			e, Maryland
Baltimore,	permit. Departra Importa any inju		21. Sign Fire of Funeral Service	Licensee		GOING HOME	of Facility Cremation	n Servic	e P.O. 1	
			23a. Part . Enter the disease, or shock, or heart failure. List	r complications that caused	the death. Do not					Approximate Interval Between
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ September 2010 5:30 Lou Burroughs Gough Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death St. Mary's 37898 Chaptico Road Chaptico 8. Date of Birth (Month, Day, Year) 08/26/1939 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday **Funeral** 1 □ M 2🗓 F Months Days Hours Min. Director 71 Maryland 215-38-7010 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2X No St. Mary's Chaptico Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number P Funeral **23**a 20621 USA 37898 Chaptico Road items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 14. Race - American Indian Black, White, etc. ò ò 1 Never Married 2 K Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Specify: "natural" Completed 3 Widowed 4 Divorced White Year or Dates event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Alternatives for and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Youth 12 Administrative Director Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Burroughs Jr. Mary Gardiner or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health item 27 i P.O. Box 25, Chaptico, MD 20621 William E. Gough Jr./Spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot 1 K Burial 2 Cremation 3 Removal from State Queen of Peace 09/23/2010 Helen, MD 4 Donation 5 Other (Specify) Licensee 21. Sig tage of Foreral Serv 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Lawara N. brinsfield Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pancreatic Cancer Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death the 8 9 Unknown r signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? s certificate has b lirector, page 2 sl performe Hospital or Attending Physician: The 1 Yes 2 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 2 X No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this or filled in by the funeral 27. Manner of Death 1 Natural 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) work? 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier соmpleted (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. re and title of certifie 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

09/20/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sept. Day 2010 21, 11:10 AM Joseph Charles Goldsborough Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 M 2 D F Months Hours Min. Country) Maryland 74 Yrs. Director 219-30-1364 March 6, 1936 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Mary's Maryland St. Hollywood 23a or 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral 44569 Clarks Landing Road 20636 or items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No Completed by 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 and 2 should be filed within 72 hours aften freath and Mental Hygiene. Item 27 is marked other than "natural", 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Home Builder Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Delmas Goldsborough Loretta Hayden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Goldsborough / Son 23250 Linden Court, Lexington Park, MD 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 and Department of Hamportant: If ite 1 X Burial 2 Cremation 3 Removal from State September 25. 4 Donation 5 Other (Specify) Charles Memorial Gardens 2010 Leonardtown, Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 Jana 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Prossible Medical Due to (or as a consequence of): Examiner Sequentially list conditions, neumon if any hading himmonicause. Enter Underlying Cause (Disease or iinjury Exami that the death certificate be executed oronary and-trans that initiated events Due to (or as a consequence of): resulting in death) Last burial-1 attending physician for use as the burla Physician/Medical Hypertens P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

Vijaya Guduri, M.D. 24035 Three Notch Road, Hollywood, Maryland 20636 SEP 23

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D68923

29d. Date signed (Month, Day, Year)

September 22, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Medic Examin	er	4a. Facility Name (if not institution, give s	·			r Location of Death	Septemb	4c. County o	
	Funeral		St. Mary s Nurs 5. Social Security Number 6. Sex	ing Center 7. Age (In yrs.	last birthe	day) If Under 1 Year	rdtown If Under 24 Hrs.	8. Date of Birtl	n	Mary s 9. Birthplace (State or Foreign
Ę	Director		577-22-3110 1 N	ØM 2 □ F 89	Y	rs. Months Days	Hours Min.	07/11/1	921 M	aryland
	and show dat	to	10a. State 10b. County	10c. C	ity, Town (or Location				10d. Inside City Limits
	Mary 28a-f	Director	Maryland St. Mary	's Holl	Lywoo					1 🗌 Yes 2 🗓 No
	with the		10e. Street and Number 24638 Hollywood R	oad		10f. Zip Code 20636			10g. Citizen of Wh J nited St	
	death items	Funeral		12. Was Decedent Ever in U Armed Forces?	.S.	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Race	- American Indian,
39	after call, or xamin	d by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give Year or Dates.		1 ☐ Yes 2 🔀 No		rican, etc.,	Black, Specify:	, White, etc.
2-0	2 hours "natur dical E	plete	15. Decedent's Edu (Specify only highest grad	ucation	16a. C	Decedent's Usual Occup Give kind of work done o	ation	ding	16b. Kind of Bus	White iness Industry
21215-0036	ithin 72 ene. • than '	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	Ti.	ife. DO NOT use retired)	•		Civil Se	arvice
<u>5</u>	filed wall Hygi	Be	17. Father's Name (First, Middle, Last)		Thre	eccionics i			Maiden Surname)	21 1 1 1 1
Maryland	uld be d Ment marker natic e	욘	Charles Henry Gib				Doris Ch			
Ma	d 2 shoalth and 27 is i		19a. Informant's Name/Relationship (Type Grace M. Gibson/W	· ·		Malling Address (Street a				ate, Zip Code) 20636
altimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	20b.	Place of D	Disposition (Name of crematory or other place	i	Date		City or Town, State
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			23a. Part 1. Enter the disease, or compliance, or heart failure. List only one		th. Do not	t enter the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician/ Medical	2 1	Immediate Cause (Final disease or condition resulting in death)	a. Quad to K	quence f	walny A	red			Onset and Death
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200	cate be executed physician and the burial-transit	edical	•	d						
Box 68	oertific ending use as	an/M	200. Was decedent pregnant	3c. If yes, outcome of pregn		3 Fetopic pregnance	***		23d. Date	of delivery
0	the att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown		5 Other (specify)			Mont	h Day Year
m	9 : 7		Part II. Other significant conditions con							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Menth 18^{ay} 201°0 Rose Marie 6:15Р м Garson **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Denton Homestead Manor (In yrs. last birthday) 8. Date of Birth (Month, Day, OT 07 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 1 M 2 F Months Days Hours Min. 019-12-9339 MASS 1922 Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 10a. State 1 Yes 2 □ No Chestertown MD Kent Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21620 208 West Campus Ave. Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 □ Yes 2 □ No Specify: 11. Marital Status Specify: White 1 ☐ Never Married 2 ☐ Married ۵ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 4 College (1-4or 5+) Elementary/Secondary (0-12) education/family tutor/homemaker 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) Sceccitano Maria Lentini Guisseppe ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 208 W. Campus Ave., Chestertown, MD 21620 Robert Garson / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Malden, MA Holy Cross Cemetery 09 22 2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lice Moore Funeral Home, P.A., 12 S. 2nd St., Denton, MD 21629 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Immediate Cause (Final oronary disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2-No 3 Probably 4 Unknown Be Completed 2 Certification: To 2

law requires that the death certificate be executed and burial-trar Division of Vital Records, P.O. Box 68760, attending physician the use as t for signed by t d be detach page 2 should certificate has Hospital or Attending Physician: The : After this certific funeral director, death.

Funeral

Director

28a-f shov

7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Modical Examinar must be nutfilled at

and Mental Hygiene.

permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is in any injury or other traum once.

Physician

/Medical

Examiner

be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

ithin 24 hours after death.

the Funeral Director: A pmpletely filled in by the fu

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-				-		24a. Was an autopsy performed? 1 □Yes 2 □No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No	э
5. Was case referr	ed to medical			26.	Place of Death (Check only one)		
examiner? 1 ☐ Yes 2 ☑	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ I	DCA Other: 4	☐ Nursing Home	e 5 Residence 6	Other (Specify)	
7. Manner of Death 1 Natural 2 Accident	n 5 □ Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes	28 2 🗆 No	d. Describe how injury	y occurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory)	ory, office	28	ff. Location (Street and City or Town, State)	d Number or Rural Route Number,)	
9a. Certifier (Check only	1 ☐ Certifying Ph 2 ☐ Medical Exam	nysician: To the best of my knowning: On the basis of examination	owledge, death occurre ation and/or investigati	ed at the time, d	ate and place, an	nd due to the cause(s) d at the time, date and	and manner as stated. I place, and due to the cause(s)	

29b. Signature and title of certifier

29c. License number

D0053255

29d. Date signed (Month, Day, Year)

2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Preston

State Registrar

Medical

and manner stated

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ DONALD GILLESPIE 2010 0022 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TENINSULA REGIONAL HICOMICO POICAL If Under 1 Year If Under 24 Hrs . Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Days Hours Min 05[%]1th8^D*1^Y9'30 Pennsylvania 289-32-9546 80 Director Usual Residence of Decedent 10c. City, Town or Location Seaford or 28a-f show 10b. County 10a State 10d. Inside City Limits Examiner must be notified at Director Sussex Delaware 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 19973 US items 23a Funeral 300 Arbutus Ave death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Vas Decedent Ever in U.S. Armed Forces?

1 12 Yes 2 10/5 4 to Year or Dates. 1956 Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after white 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired)
Mechanical Engineer (Specify only highest grade completed) should be filed within 72 l n and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Chemical Be 18. Mother's Name (First, Middle, Maiden Surname) Ruth Benson 17. Father's Name (First, Middle, Last) Lyman Gillespie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Arbutus Ave, Seaford, DE 19973 19a. Informant's Name/Relationship (Type, Print) David Gillespie -1 and 2 si of Health a item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place)

Odd Fellows Cem. 1 X Burial 2 Cremation 3 Removal from State 09/18/2010 Seaford, 4 Donation 5 Other (Specify) 21. Signature of Funeral /e Cranston Fulleral Home P O Box 967, Seaford, John A. Cranston 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Metas tota Prostate Medical resulting in death) Due to (or as a consequence of): **Examiner** Renal Facilie Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events -tran resulting in death) Last Due to (or as a consequence of). attending physician a for use as the burial-Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No g Unknown g Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director, After this certificate I 2 X No Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1 No 1 X Inpatient 2 ER/Outpatient 3 DOA 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) မ 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural iniury work? 1 🗆 Yes 2 🗆 No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

Registrar

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31. Date filed (Month Day Year) 5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100E. Carroll St.

32. Eggistrar's Signature

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md.

09-14-10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hudson 10:30 PM Elizabeth Sentembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Examiner Piata Medical -a Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** May 24 , 1909 1 □ M 2XXF Months Days Hours 214-60-3397 New Jersey 101 **Director** Usual Residence of Decedent 28a-f shov 10b County 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f shore Examiner must be notified at Funeral Director La Plata MD Charles 1 🗌 Yes 2 🔽 No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? U. S. A. 20646 11635 Farm Drive 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White Completed **¾**XWidowed 4 ☐ Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker At Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irene Gray Edward H. Davis 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Virginia Cooksey Farm Drive La Plata, Maryland 20646 11635 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September 1 X Burial 2 Cremation 3 Removal from State Trinity Mem.Grdn. 30,2010 Waldorf, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Raymond Funl. Service, P.A. Lever Basta M00641 5635 Washington Ave., La Plata, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Ducity for as a sunsequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 ☐ Yes 2 ₹ 9 ☐ Unknown page 2 should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by bRILLATION 1 ☐ Yes 2 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performe death? 1 Yes 2 No L Yes 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending after death. 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Qertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

3

NDIN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

4436

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2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 11:15 P M September 201 Frances Ε. Horton Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Kline Hospice House <u>Frederick</u> Airy 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** Months Days July 24, 1919 1 M 2 X I Hours Min. Maryland 220-16-1289 91 **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🛣 No Maryland | Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 5524 Woodlyn Road 21703 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 Married 2 🔀 No Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: If Yes, Give Specify: 3 X Widowed 4 ☐ Divorced Year or Dates 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Health and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ William Mayne Mary Shipley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Portner / Daughter 5524 Woodlyn Road Maryland 21703 Frederick, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite any injury or ot 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State September 4 Donation 5 Other (Specify) Poplar Springs Cem. Mt. Airy, Maryland 2010 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the sisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due t consequence of) Examine Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed detached for use as the burial-transi To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth
4 Pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 1 Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Director: After this certificate has I autopsy performe 1 🗌 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending work? 1 ☐ Yes 2 ☐ No 1 Natural Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

24 hours within 2 To the I ည

> State Registrar

Medical

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1/🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 Phys Mo Exa To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760

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Physiciar Medica	al			Hardest					Septembe:	_			11:0	6 P ^M
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		27445 Bude 5. Social Security Num			Age (In yrs. Ia	est birthday)	Mech	anicsvill	8. Date of Birtl	h	St. 1	Birthplac	e (State or	Foreign
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	iner	Sequentially list con if any, leading to import	nditions, mediate	b. Due to (or	as a conseq	sequence of):								
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e exe		resulting in death) L	ast	,	as a conseq	derice oi).								
or Attending Physician: The law requires that the death certificate be exe after death. after death. Director: After this certificate has been signed by the attending physician a birector. After the seas the burial in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medical			d										
eath certifica attending p	Σ	IF FEMALE: 23b. Was decedent p		23c. If yes, outco	me of pregna	ancy	☐ Ectopic pregnan	acv.			23d. Date of	delivery		
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si cian ; Th certificat rector, pa	Be C	25. Was case referre	ed to medical				26. F	Place of Death (Che		2 11		100		
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ding Ph h. After thi funeral		27. Manner of Death 1 Natural	5 Pending	28a. Date of (Month,	injury Day, Year)	28b. Time injury	wo	ıryat rk? ∐Yes 2 □ No	28d. Describe	how inju	ry occurred			
ttend death ctor: / the f	Certificate:	2 Accident 3 Suicide	Investigate 6 Could no	t be 28e Place of	Injury - At h	ome, farm,	M 1 L		28f. Location (r Rural R	oute Numb	er,
al or A s after I Direct		4 Homicide	determine	ed building	, etc. (Specif	y)			City or To	wn, State	e) 			
To the Hospital or Attendit within 24 hours after death. To the Funeral Director: Af	Medical	(Cheek 2	Medical Eve	Physician: To the bes aminer: On the basis	of examination	on and/or inv	estigation, in my opin	nion, death occurred	at the time, date	and place	e, and due to	the caus	ie(s) and mai	nner stated.
the H hin 24 the Fi	Me	only one) 3	Certifying N	lurse Practioner: To	the best of m	ny knowledg	e, death occurred at t	the time, date and pla se number	ace, and due to th	ne cause	(s) and manne ate signed (M	er as state	ed.	
Vit Co		29b. Signature and t	title of certifier /	3	6	a		oco 50	06	29u. Da			2010	5
		30. Name and addre	ess of person with	no completed cause	of death (Iter				7		. / 4	[
10		Leon W. B					age Road,	Mechanio	sville,	MD	20659			
Sta		31. Date filed (Month	h, Day, Year)	32. Reg	istrar's Signa	ature								
Registr	ar	S	EP 21	ZUTU Bu	wa,	B. A	ranke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month September 22, 2010 Year Physician/ 10:22_{A M} Ella Louise Hemming Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year, April 13, 19 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Country) Maryland Hours Director 96 220-80-9411 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1 Tes 2 No St. Mary's Hollywood Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20636 25441 Hemming Lane USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces?

1 Yes 2X No Black White etc δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: White 3 ₺ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Peter Henry Harris Catherine Eleanora Goldsborough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25441 Heemming Lane Hollywood, MD Mary Louise Farmer Meekins/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
St. John's Catholic Church
Cemetery 1 X Burial 2 Cremation 3 Removal from State September 27, 4 ☐ Donation 5 ☐ Other (Specify) 2010 Hollywood, Maryland Signature of Funeral Service Livery 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD Nava 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final CARDIORESPIRATORY Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 2DAYS RESPIRATORY Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events 20Ays AND SEPTIC SHOCK the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? after death.

Director: After this certificate has autopsy performed 2 No 1 ☐ Yes 2 ☑ No I Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Norse Practioner T, the Lest of my knowledge 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD willen D69663 09/22/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 23500 Point Lookout Rd MALINI LEONARDTOWN MD 200 31. Date filed (Month, Day, Year) SEP 23 2010

DHMH 17 Rev 7/2009

State Registrar

-temmino

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar 1. Decedent's Name (First, Middle, Last)					2.	Date of Deat	th		3. Time of Death	
	Physici		Bernice	Hastings					Month eptembe	Day	Year 4. 2010	2303 M	í
1	/Medic Examin		4a. Facility Name (If not institution, give street ar			4b. City, Town, or	r Location of		ресшь	_	County of Death	2303	_
a family	LAGIIIII		212 Bloomingdale Ave	nue		Federa	alsbur	rg		C	aroline		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. i		If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day	Year)	9. Birthp Cour	place (State or Foreig	n
nis.	Director		219-36-6505	102	Yrs.	Monato Bayo		1	ugust .			yland	_
	and		Usual Residence of Decedent 10a, State 10b, County	10c. City	y, Town or Lo	cation		-			1	0d. Inside City Limits	
	/aryi	ō	Maryland Caroline			eralsbur	œ					1 ☐ Yes 2 ☐ No)
	the N	rec	10e. Street and Number		100	10f, Zip Code	5		1	0q. Citiz	zen of What Cour		_
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	ms 2	by Funeral Director	11 Marital Status 12. Was	Decedent Ever in U.	S. 13. \	Was Decedent of H	lispanic Orig	gin? (Specify			4. Race - Americ	can Indian,	
9	or ite	J.	1 Never Married 2 Married 1	ed Forces? Yes 2 🙀 No		t Yes, specity Cuba I∐Yes 2 [Σ]No	an, Mexican, Specify:	, Puerto Rica	an, etc.)		Black, White,	etc.	
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2	72 h "natu	ete	15. Decedent's Education (Specify only highest grade comple	eted)	(Give	dent's Usual Occup kind of work done	durina most	of working		16b. Kir	nd of Business/In-	dustry	
12	within ene. than	Completed	Elementary/Secondary (0-12) Colle	ege (1-4or 5+)		cher/Libi	,			Boo	ard of Ed	ucotion	
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an	d be ental ked c	To Be	W. G. Wooters				Nett	ve F	orter				
Maryland	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. I marked other than "natural", or items 23a or 28a-f show umatic event, I'm Marylan Exacil normalls in with all and I was a show in the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked o	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street		-		r, City or	Town, State, Zip	^{Code)} 20678	
	1 and 2 Health a tem 27 is		Gary Hastings Nephe	ew								Maryland_	
e,	of He litem		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place	ce)	Date	,	20c. Loc	cation - City or To	own, State	
altimore,	Pages nent of I ant: If Ite		1 ABurial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State _	_	emetery		7/17/2	010	Der	nton, Ma	rvland	
a	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. In Medical Exaction must be notified an once.		21. Signature of Funeral Service Lichnee		22	. Name and Addre	ss of Facility	Moor					
<u> </u>	9 9 E 8 9		Pauleper 1804	2	1	2 South S	Second	Stre	et, De	ntor	n, Maryl	and 21629	
п			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death on each line.	n. Do not ent	er the mode of dyir	ng, such as	cardiac or re	espiratory arr	rest,		Approximate Interval Between	
- C	Physician	i	Immediate Cause (Final disease or condition	unushue	Vec	It Fail	UM					Onset and Death	
1	/Medical Examiner		resulting in death)	ie to (as a consequ	uence of):								
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	the H nin 24 the F	Medical	one) and	manner stated.	tion and/or in			IIII occurred					
_	70 Vit	2	29b. Signature and title of certifier			29c. Licens					e signed (Month,	Day, Year)	
			16.1.			C1-	- 000	8167		Sep	puber 1	6,2010	
			30. Name and address of person who completed	cause of death (Item	1 23a) (Type,	CI-	10	. 1	, 0	ſ	r 2 T		
	Sta	to.	31. Date filed (Month, Day, Year)	∬ (3 32. ≸egistrar's Signa	Lo M	iddle los	1 Rd	Seah	10 VI	159	11-		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 15, Carroll W. Jones 5:22 A 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Prince George's **Examiner** Ft. Washington George's Assisted Living 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XXM 2 🗆 F Months Hours 88 (197224 F921 Virginia Director 577-22-6152 Usual Residence of Decedent or 28a-f show 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland 1 Tes 2 X No Marvland Prince George's Ft. Washington Ξ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 Notley Road 20744 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 KMNo Specify. If Yes, Give White Specify 3XX Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 in and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Warehouseman Department Store 6 years other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert W. **Estelle** Jones Susan Hamlette permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Brooke / Daughter 19437 Breezedale Lane Germantown, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, Mt. Olivet Cem. 1xxBurial 2 ☐ Cremation 3 ☐ Removal from State 09/21/2010 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA Fune al Service Licensee 21. Signatur U. 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a, Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Emysician/ disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, Due to or as a consequence of if any leading to immediate cause. Enter Underlying Exami the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. Cause (Disease or iinjury that initiated events and -tran: Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) signed by the a 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig page 2 should b 2 No 3 Probably 4 X Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate Yes 2XX No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **X** XIo Other: 4 D Nursing Home 5 D Residence 6 Kother (Specify) Assisted P 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral is 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 XXNatural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARONS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2010 11:00a M 09 15 Sarah Irene Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Georges Ft. Washington Medical Center Ft. Washington 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕅 F Months Days Hours Min. Director 213-34-7763 19 1938 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if firem 27 is marked other than "natural", or them 27 any injury or other trainment 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director Oxon Hill MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5602 Livington Terrace #202 Funeral 20745 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. <u>≥</u> Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housing Supervisor Apartments/ Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clyde Smith Alice Sollers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Diane Williams/ Daughter 12717 Radburn Place Ft. Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State Ft. Lincoln Cemetery 09/21/2010 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Road Brentwood, MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Earl disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 1,2 m Month Year Day 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 📉 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 No 1 □ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760. Hospital or Attending Physician: The 24 hours after deat Funeral Director; filled in by the completely within 2 o the F

Medical

DHMH 17 Rev 1/2001

State

determined

62

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 234) (Type, Print)

4 Homicide

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day,

Shantha Murphy

7 2010

Year)

29a, Certifier

one)

6196 Oxon Hill Rd Suite 520

152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

06

Oxon Hill, MD

29d. Date signed (Month, Day, Year)

20745

16/10

Please Type or Print in Black Indelible Ink4 Figure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month $A^{\ M}$ **Physician** 6:00 09 20 10 Wilbur Levengood Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Denton Envoy of Denton Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Min. Hours Months Days 1 M 2 □ F 83 10/12/1926 PA 192-20-1425 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10b. County 10a. State show r 28a-f show notified at 1 ☐ Yes 2 🙀 No Goldsboro Director Caroline MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ns 23a or 2 must be n death with United States 21636 25799 Bridgetown Rd. Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iter 1 □X(es 2 □ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 No 1 ☐ Yes 2 ☐ XVo Specify. Baltimore, Maryland 21215-0036 Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other than "natu 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufactoring Shipping & Receiving 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Esther Moyer Levengood Louis Herman Levengood ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any injury or other traconce. Spouse / Mabel Levengood Goldsboro, MD 21636 25799 Bridgetown Rd, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crm. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chester, MD Helfenbein 9/21/10 ity Fleegle 4 ☐ Donation 5 ☐ Other (Specify) Cntr. Funeral & 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PO Box MD 21639 160, Greensboro, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STAGG Physician FND /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-trar the attending physician and hed for use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown ALNTIA 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 🔼 No 24a. Was an autopsy performed? Yes 2 No 1⊟ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 20 No 1 🔲 Inpatient ို 1 ☐ Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Medical Certification: Injury 5 Pending investigation 1 Natural 1 □ Yes 2 □ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide determined filled in by 4 🗌 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only To the 29c. License number who completed cause of death (Item 23a) (Type_Print) 30. Name and add DOMINGBALE AUX FEDERALS BURG, MD 32. Registrar's Signature State

10+1

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 30744 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Gail J. Mayhew Medical 26,2entember 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Montgomery Hospice Casey House Rockville <u>Montgomerv</u> Social Security Number If Under 1 8. Date of Birth (Month, Day, Sept. 1 If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Hours Min 1 M 2 ST Months **Director** 436-76-8048 Louisiana Usual Residence of Decedent rshow 10a. State 10b. County ed other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD PG <u>Hvattsville</u> 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral i 923 Vauxhall Road 20785 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Specify: Completed 3 ➡ Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Fed Govt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic in ene. traumatic Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 923 Vauxhall Road Hyattsville, MD. Theresa Beverly/daughter 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Harmony Memorial Park 10/1/**1**0 Landover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Lue to (or as a consequence or). To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed Thyroid Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an . Were autopsy findings available prior to completion of cause of cate has t page 2 s autopsy death? certificate 2 LANG 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE IPU After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending injury 2 🗆 No within 24 hours after death

To the Funeral Director: / Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Muncaster 31. Date filed (Month, Day, Year,

DHMH 17 Rev 7/2009

State

Registrar

Signature

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amend Flease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 10 30745 State Registrar Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 10, 2010 Physician/ 11:10 Elizabeth Mogle Noreen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 29994 St. James Way Somerset Princess Anne Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🏝 F Days Hours 11/27/1946 220-46-2966 63 Maryland **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at ould be filed within 72 hours after death with the Maryland of Mental Hygiene.

marked other than "natural", or items 23a or 28a f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🛚 Yes 2 🗆 No Maryland Somerset Princess Anne 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29994 St. James Way 21853 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ρ 1 \square Never Married 2 \square Married 1 ☐ Yes 2 🕱 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed white 3 XWidowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) recreation director nursing home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Kathryn Noreen Bradley Paul Levan Dawkins 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29994 St. James Way, Princess Anne, MD 21853 Jannifer E. Mogle/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Eastern shore of a MD 9/14/2010 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, MD Veterans Cemetery ²Horloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 of Francial Survice Licensee لهتد CFSP 0200 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Sarcoma disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** 1.5 yr Breast Sarcoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for as a to seque to of or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 🗶 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Yes 2 No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗶 No 1 🗌 Yes ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 A Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury **X**Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral C Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature an title

State Registrar 31. Date filed (Month, Day, Year)

5 2010

completed cause of death (Item 23a) (Type, Print)

11-20500

TOSEPH H. GRASSO

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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		Althea Wo 5. Social Security N		Nursing 6. Sex	7. Age (In yrs. i	last hirthday)	Silv If Under		pring If Under 24 I	Hre o	Date of Dist		ntgome:		(0)
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na Abigal Mu				19b. Mailin	g Address N. Le	(Street ar eisur	nd Number or \mathbb{R}^{n}	r Rural Ro L d Bl	oute Number	; City or Tov	wn, State, Zip ilver	code Spr	20906 ing, MD
of Hex of Hex If item or othe		20a. Method of Disp		3 Removal from		Place of Dispos cemetery, crem	sition (Nan	ne of ther place)	Date	,	20c. Loca	tion - City or	Town,	State
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permi Depar Impor any in		21. Signature of Fui	11. 4	14-11-11	/								.O. Bo		
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Physician/		Immediate Cause (disease or condition	Final	nly one cause on ea Mali	gnant	Brain	Tum	or							erval Between set and Death
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aw req as bee 2 shor	plet										24a. Was a		24b. Were aut	topsy f	findings available etion of cause of
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sician certifi irector	m	25. Was case referre examiner? 1 ☐ Yes 2 ☐		Hospital:		FD/0:		Other	ce of Death (C		<u> </u>				
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al or At s after o		4 Homicide	determi	ined 28e. Place	of Injury - At hong, etc. (Specify	ome, farm, stre	et, factory	, office		28f.	Location (S City or Town		umber or Rur	al Rou	ite Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2	Medical E	Physician: To the b xaminer: On the bas	is of examination	n and/or investi	gation, in r	ny opinion	, death occurr	red at the	time, date ar	nd place, and	d due to the o	ause(s	s) and manner stated.
To the within To the compl		only one) 3 29b. Signature and		Nurse Practioner:	to the best of m	y knowledge, d		License r		d place, ar			id manner as igned (Month		
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State Registra	_	31. Date filed (Monti	h, Day, Year) SEP 17	2010 32.9	egistrar's Signa	ture	es plan	,							
			VIET OF		A PARTY MANAGEMENT AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PARTY AN	10 1 749	B. 200								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

10-07244 Gary Wayne Nelson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 10 10 3074

		1- For State Registrar	,	Cert	ificate of	Death			Reg.	No.			
Physici	an/	Decedent's Name (First, Middle,Last)						2. Date of Death Month Day Year 3. Time of Death					
Medical Exami	ner			elson				8	September 2	20, 2010		0803 hrs	
		4a. Facility Name (if not institute 628 Hayes Avenue	ion, give street and number	et and number)			4b. City, Town, or Location of Death Hagerstown			4c. County o			
Funeral		5. Social Security Number		r 24Hrs. 8	. Date of Birth(place (State or					
Director		Months Days Hours Min								Foreign			
		217-86-8766 1 M 2 F 40 Yrs. World 03/25/1970 Cour											
any		10a. State 10b. County 10c. City, Town or Location										10d. Inside City Limits	
* "	_	Maryland Washington Keedysville										1 Yes 2 No	
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code							10g.	10g. Citizen of What Country?			
with the Maryland ns 23a or 28a-f sho be notified at once	ä	3522 Chestnut Grove Rd. 21756								U.S.A	_		
with ns 23 be no	rai	11. Marital Status	12. Was Deceder			Decedent of H	ispanic Origi			14. Race -	America	an Indian, Black,	
death or iter	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto F						Puerto Rica	Rican, etc.) White, etc.				
afte.	by	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16				Yes 2 No specify: a. Decedent's Usual Occupation (Give kind of work done)				Specify: White 16b. Kind of Business/Industry			
5-0036 led within 72 hours Hygiene. other than "natur:					16a. Decedent during mo	's Usual Occupa est of working life	ation (Give k e. DO NOT u	ind of work use retired)	done 16	6b. Kind of Bus	iness/Ind	dustry	
36 iin 72 han dical	e e	Elementary/Secondary (0-12) College (1-4 or	5+)	A O	1161	1	TT		0			
d with	Completed	9 17. Father's Name (First, Middle	e, Last)		Air Co	nditing			ng st, Middle, Mai	Contradiden Surname)	ctor		
21215-0C Muld be filed wit Mental Hygier marked other c event, the M	-	James Nelson	•				Mary	E.	Spring	rer			
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umastic event, the Medisa		19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailing	Address (Stre		ber or Rura	Route Numbe	er, City or Town	, State, Z	Zip Code)	
nore, MD 2 ages I and 2 shou nt of Health and N t: If item 27 is r			. / Brother		14428	Brair V	/alley	Road	Clear	Spring	217	22	
		20a. Method of Disposition 1 Burial 2 Crematic	on 3 Removal from S		ace of Dispositematory or oth	tion (Name of ce er place)	emetery,	Da	ate 2	20c. Location - 0	City or To	own, State	
Baltimore, permit. Pages I as Department of He Important: If ite		4 Donation 5 Other S		late			orv	09/26	/2010 5	Smithsh	ure	Marvland	
Baltimo permit. Page Department of Important: injury or oth	ı	4 Donation 5 Other Specify: Smithsburg Crematory 09/26/2010 Sm 21. Signature of Funeral Service Logisee 22. Name and Address of Facility Rest Haven Ft								uneral	Cha	pel	
E. F. P. E.		1601 Pennsylvania Ave. Hagerstown Maryland 2174											
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and											
Medical Examiner	Narcotic intoxicaiton										Death		
		or condition resulting in death)	Due to (or as a con:	sequence of):									
	- l	Sequentially list conditions, if any, leading to immediate b									-		
	Examine	cause. Enter Underlying Cause											
ed sait	Z	events resulting in death) Last Due to (or as a consequence of):											
760, icate be executed sphysician and the burial - transit		UNPENDED AMENDED											
760, icate be e g physicial the burial	Medical					r ME g9	08 10/	8/10	TT	001 0-1-1			
876 tificat ng ph		IF FEMALE: 23b. Was decedent pregnant in	the 23c. If yes, outco	me of pregna		al death 3	Ectopic	pregnancy		23d. Date of d Month	ielivery Da _i	y Year	
Box 687 e death certifi the attending	<u> S</u>	past 12 months?	2 months? 4 Pregnant at time of death 5 Other (Specify)										
Bo e dear	Physician		g Unknown										
P.O. es that the igned by be detach	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown				
8 8 8	eq	Cardiomegaly											
cords law requi has been	Completed								24a. Was an autopsy	pri	or to cor	npletion of cause of	
Rec The la	ĕ								performe 1 ✓ Yes 2		ath? ✓ Yes	2 No	
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical 26. Place of Death (Check only one) examiner?											
n of Vital ing Physician: After this certifianeral director,	P	1 Yes 2 No No No No No No No No											
n of ding Ph	ᇙ	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury unk								v injury occurred	d		
Sior vrtenc death ctor: y the	渡	Natural 5 Pending Investigation Pd 9/20/10 Fd 8:00 am 1 Yes 2 X No Unk								(Street and Number of Burel Boute Number City			
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been sompletely filled in by the funeral director, page 2 should the completely filled in by the funeral director.	Certification:	3 Suicide 6 X Could not be determined (Specify) Sound: private dwelling etc. (Specify) found: private dwelling							or Town, State	e 628 _M HA	yes	Route Number, City Ave	
ospits hours unera y fille		200 Coeffice											
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)											
To To com	Med	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date sign							9d, Date signed	(Month	ı, Day, Year)		
	==	his his, mo				O.C.M.E.				September 21, 2010			
	}	30. Name and address of person who completed cause of death (Item 23a)											
		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature											
Regis	trar	9	GL 3 0 KOIO	Leson	w pl.	A COSE	ad						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** TCHOLSON 2010 ocumbus /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SAUSBURY GERMANIA WICOMICO (I socie If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months Hours 1**3**M 2□F 240-46-5163 North Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 Yes 2 No WICOMICO 7 is marked other than "natural", or items 23a or 28a-f st traumatic event, the Medical Examiner must be notified SALJSBURY Director 10g. Citizen of What Country? 10e. Street and Number USA 616 GERMANDIA 21801 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 RYes 2 No If Yes, Give Year or Dates: ARMY 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No BLACK Saltimore, Maryland 21215-0036 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) METRI d 2 should be filed within th and Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) ABORER 18. Mother's Name (First, Middle, Maiden Surnam 17. Father's Name (First, Middle, Last) Be mit. Pages 1 and 2 should be partment of Health and Menta portant: If item 27 is marked y injury or other traumatic ev WICHOLSON MARTIN LEOLA SHERMAN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SistER SALTS BUNG IND SALE
ate 20c. Location - City or Town, State Dower 21804 PAMIE Louise 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Huntock, MD Department of Important: If any injury or Enstend SHENE VET 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee STEWARY FURRAL Home (FSP 23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ASCNO Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Lijury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 □Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an autopsy performed? 1□ Yes 2□ No certificate | 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 ☐ Nursing Home 15 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes PNO 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manper of Death 28c. Injury at Work? After (Month, Day Year) 5 Pending investigation Natural To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 063179 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) DR. Vohro 31. Date filed (Month, Day, Year) State 16 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ P^{M} Claude Bruce Porter September 2010 1:06 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Kline Hospice House Mount Airy 6. Sex 1 **X** M 2 □ F If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye. June 28, 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In vrs. last birthday Funeral Days Director 215-20-9598 81 Ju<u>ne</u> Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 X Yes 2 □ No Marvland Frederick Brunswick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21716 710 Second Avenue United States ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black White etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White "natural", 3 X Widowed 4 □ Divorced Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) e 1 and 2 should be filed within 72 Pof Health and Mental Hygiene.
If item 27 is marked other than "nor other traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Vice President Banks Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Claude Porter Louise Virginia Nicodemus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neil Porter / Son 710 Second Avenue, Brunswick, Maryland 21716 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place, 1 X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 27, 2010 Olivet Cemetery Frederick, Maryland 21. Signature f Funeral Service Licen Keenev andssEasTord PA Funeral Home MO1473 106 E. Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Ener U. denying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ate has been signed by the atterpage 2 should be detached for a Month Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No Yes 2 within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 100 Hospital မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of De th Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injuly occurred work? Natural iniury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one 29b. Signati 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric Bush.

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's

Davs

Months

4b. City, Town, or Location of Death Princess Anne

Hours

Min.

4c. County of Death

U.S.A.

48154

Approximate Interval Between Onset and Death

Since Birth

one week

Year

21817

Month

Day

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

September 13th 2010

8. Date of Birth Month, Day, Year) 08/08/1942

9. Birthplace (State or Foreign Country) Maryland

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

Physician /Medical **Examiner**

4a. Facility Name (If not institution, give street and number)

Manor

1 □ M 2 🛛 F

Manokin

Social Security Number

219-76-6908

Usual Residence of Decedent

Funeral Director

28a-f show If than "natural", or items 23a or 28a-f show the Medical Examination ust be notified at within 72 and Mental Hygiene. ould be f injury or other traumatic

Baltimore, Maryland 21215-0036

000

2

Physician /Medical Examiner

certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit After this certificate has funeral director, To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After t completely filled in by the funera

of Vital Records, P.O. Box 68760,

Julia A. Pohlman

10c. City, Town or Location 10a, State 10b. County Maryland Somerset Princess Anne Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21853 11974 Edge Hill Terrace by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑No 11. Marital Status 1 X Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: Specity: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None 18. Mother's Name (First, Middle, Maiden Surname)

Rauser
Elizabeth Margaret Hauser** 17. Father's Name (First, Middle, Last) Be Henry George Pohlman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau
once. Dorothy M. Bobrowicz (Sister) 34473 Grove Drive - Livonia, Michigan 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarva 09/14/2010 5 ☐ Other (Specify) Delmar, DE 4 ☐ Donation 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, 21. Signature Robert H. Bradshaw, Jr. 23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final SYNDRUME disease or condition resulting in death) Due to (or as a consequence of): PNEUMONIA Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 1 🗆 Yes Completed 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 W Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier,

7. Age (In yrs. last birthday)

68

Registrar DHMH 17 Rev 1/2001

State

who No

DR. USHA

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEP 1 6 2010

NATESAN

32. Registrar's Signature

Cenera

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1415 . S. DIVISION Si, SALISBURY MD 21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9/24/2010 JOANNA LYN PHILLIPS RICHARDS 5:46 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2509 OLD HOUSE PT. RD FISHING CREEK **DORCHESTER** Date of Birth (Month, Day, Year) 8/5/1965 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2X F Dountry) MARYLAND 218-98-7102 45 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits show 10b. County 10c. City. Town or Location 10a. State 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be mailfied at Director 1 Yes 2 No PENNSYLVANIA YORK MT. WOLF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25 HORSESHOE BEND RD. 17347 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ 3 Widowed 4X Divorced WHITE Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HORSE TRAINER **EQUINE** 10 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any injury or other traumatte event, once. 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) RUSSELL CALVIN PHILLIPS, SR. JUDITH ANN GADOW ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDITH ANN PHILLIPS / MOTHER 2509 OLD HOUSE PT. RD., FISHING CREEK, MD 21634 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 9/27/2010 CAMBRIDGE, MD MID SHORE CREMATION CENTER 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST, CAMBRIDGE, MD 21613 -23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final . Physician 1cta sta disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (briss a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Puneral Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ó in the past 12 months? 1 ☐ Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 ANo 2 🗆 No 1 ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

State Registrar

within 2

(Check only one)

30 Name and

29b. Signature and title of certifier

31. Date filed (Month, Day,

1Cia

Year)

DHMH 17 Rev 1/2001

32. Registrar's

and manner stated

address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

St Cambridge

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 30752 State of Maryland / Department of Health and Mental Hygiene [] For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 8, 2010 Physician/ David Neal Rector 10:30 a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Salisbury 5900 Rockawalkin Road 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours 0471471980 Mary land 50 **Director** 212-78-2102 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 K No Salisbury Wicomico Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 USA 5900 Rockawalkin Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. permit, Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: white Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Dccupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) United Methodist Church minister Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edith Harvey Bayne Rector 19a. Informant's Name/Relationship (Type, Print)
Patti Rector/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5900 Rockawalkin Rd., Salisbury, MD 21801 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory of other place)
Rockawalkin U.M.
Church Cemetery 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 9/12/2010 Hebron, MD 4 Donation 5 Other (Specify) . Signature of Funeral Service Liven ee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Cell 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

5 years Immediate Cause (Final Ph_sician/ <u>years</u> disease or condition resulting in death) Metastatic Colon Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or liniury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 🗷 Residence 6 Nother (Specify) 1 🗌 Yes 2 🔀 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 050 2010 30. Name and addre 31. Date filed (Month, Day, 32 egistrar's Signature

State

Registrar

5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2230 Shewbridge Rev. Florence Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany WMHS-RMC Cumberland If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 8 Date of Birth 7. Age (In vrs. last birthday) Birthpiac Country) OH **Funeral** Jan 10 1 🗆 M 2 🖵 F Director 83 220-16-6353 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Types 2 No MD Allegany Rawlings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21557 USA 16117 Rawlings Heights Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced Year or Dates white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12 College (1-4 or 5+) Pastor Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Elva C. (Weller) Brotemarkle James H. Brotemarkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD11721 Bedford Road Cumberland <u>Sharon Keefer</u> Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/29/2010 Hillcrest Memorial Park Cumberland MD Signature of Funeral Service Licensee ^{22. Nam}Scarpellis Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Death Immediate Cause (Final Bilale Physician/ disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter on Janying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d, Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 1 Yes 2 No Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Leaftifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the cast of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 29b. Signature and title of bett 29c. License number 29d. Date signed (Month, Day, Year) DOU 33280 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 Kent Avenue Cumberland MD 21502 Sunil Gupta M.D 31. Date filed (Month, Dav. Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

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imore, MD 2121! Pages I and 2 should be fill nent of Health and Mental I lant: If item 27 is marked or other traumatic event, i	ı	Linda Stogdale / Sister 20a. Method of Disposition			osition (Name of ce		Date	20c. Location - City	
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Di Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying Physician: To the best	of my knowledge	e, death occ	urred at the time, d	ate and place, ar	nd due to the cause	e(s) and manner as s	stated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of and manner st	f examination an	d/or investig	ation, in my opinior	n, death occurred	at the time, date	and place, and due to	the cause(s)
F. 8 7 8	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Month, Day, Year)
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		30. Name and address of person who completed caus					NE LIE		
			edical Exam		1 Penn Street	, Baltimore, I	MD 21201		
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Registrar

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cem	etery, crema	atory or or	her place							
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 to ompleted filled in by the funeral director, page 2.	I Ce	4 - Hornicide determined	building, etc. (Specify)					City or To	wn, State	:)			
ospit hour unera	edical	29a. Certifier 1 Certifying Physicis (Check 2 Medical Examiner	an: To the best of my	y knowledg	ge, death oc	cured at	the time,	date and place,	and due to the c	ause(s) a	nd manner	as stated	d.	oner stated
the H in 24 the Fi	Me	only one) 3 Certifying Nurse F												ner stateu.
70 Viti		29b. Signature and title of certifier	1/2				License				te signed			10
		M KUZI) owne	109				676			111	lent,	TERL	11 20	10
<		30. Name and address of person who com MANUEL FREZ-BONNE	11	th (Item 23	Ba) (Type, Pri	int)	01	(:L-	222 Pin	ecus.	11= 1	100	1208	
> Stat	Α.	Od Data filed (Month Day Vene)	32. Registrar's	Signature		VWN	100	2UTE	cic IM	FIVE	IF N	(1) 2	1200	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

State Amend #20b, 9-16-2010, per FHDR till Bordenth Registrar Amend #20b, 9-17-2010, per FHDR till Bordenth Reg. No.

1. Decedent's Name (First, Middle, Last) Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3. Time of Death Physician/ Month 1Bay 2010 2:45 P M Ann Marie Schleicher Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Woodstock Howard 2158 Turnberry Way Birthplace (State or Foreign Country)

MA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Davs Hours Min. M27241930 018-22-0581 79 Yrs MA Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Woodstock MD Howard 10f. Zip Code 10e. Street and Number 2158 Turnberry Way 10g. Citizen of What Country? 21163 Funeral United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates 3 → Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Telecommunications Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Brothers Anthony Leo Ward other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9642 Sparrow Ct. Ellicott City, MD 21042 Pam Jones - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington Ntl. Cemt. 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Arlington, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHarry H. Witzke's Family F.H. Inc. M00845 10 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) cancer <u>una</u> Years Medical Due to (or a sonsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery signed by the atte in the past 12 months? Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 2 1 2 X No certificate Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XResidence 6 Other (Specify) 27. Manner of Death 1 XNatural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

Box 68760 P.O. Records, within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, **Division of Vital** Hospital or Attending

> State Registrar

29a. Certifier

(Check only one 29b. Signature and

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10711 Birmingham

D0057136 16/10

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Woodstock, mo 21163

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Day Of M **Physician** CHAPMA Setempto 11, 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 🛣 M 2 🗆 F Yrs. 09/04/1954 Director 215-70-1706 56 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits or 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 XNo Director St. Mary's Hollywood Maryland 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Numbe ö r items 23a or ner must be n 20636 25085 Vista Road USA Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No 14. Race - American Indian, 11. Marital Status Black, White, etc. ral", or iter Examiner 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify If Yes, Give Year or Dates: Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry th and Mental Hygiene.

7 is marked other than "natul traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Harry Lundeberg Elementary/Secondary (0-12) College (1-4 or 5+) 12 <u>Maintenance Director</u> <u>School</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samue1 С. Spalding, Sr. Alice Abell ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau Victoria Spalding/ Spouse 25085 Vista Rd., Hollywood, MD 20636 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 09/21/2010 Hollywood, MD 4 ☐ Donation 5 ☐ Other (Specify) St. John Francis 21. Si pature uneral Service Ricenses 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) عاميا CANCER /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uncaus or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed g physician and as the burial-trans Due to (or as a consequence of) Box 68760 Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy Physician/ 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the at detached 2 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by ate has been signe page 2 should be 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: 1 ☐ Yes 2 🕱 No 1 Alnpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation s after death. 2 Accident 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Funeral L Hospital 29a. Certifier 🛮 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely

within 2 To the I 10 ame

HUTCHAUN ATSOR gistrar's Signature 31. Date filed (Month, Day, Year) SEP 2 0 2010 barles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifie

29c. License number

RES - 00 0

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Saprensez 17, 2010

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death SEPT. **Physician** 20 1°0 2248 Betty Charlotte Sanders 16, М /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hurlock Dorchester 5862 Cloverdale Road 9. Birthplace (State or Foreign Country) New Jersey 8. Date of Birth (Month, Day, Oct. 5, 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. **Funeral** Days Months Hours Min. 1 □ M 2 🕅 F 1918 91 213-03-4689 Oct. Director Usual Residence of Decedent death with the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State d other than "natural", or Items 23a or 28a-f show event, the Wedical Evan, I are must be reattled at Hurlock 1 Tyes % TXNo Dorchester Director MD 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code 21643 5862 Cloverdale Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐Yes 2X☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify: ģ White 3x Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sewing Factories Seamstress . Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tant: If Item 27 is marked other th lury or other traumatic event, Item 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Edward Hollerman, Helen Clark ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5862 Cloverdale Rd., Hurlock, MD 21643 Helen Taylor/Niece permit. Pages 1 and Department of Heal Important: If Item 2 any Injury or other Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Choptank, Maryland 1 TrBurial 2 Cremation 3 Removal from State Belmont Cemetery 09/20/10 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Christia M. Coale 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown oxy topen Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No huperglycem 24a Was an autopsy fibrillah certificate 1 ☐ Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Path 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide thin 24 hours a the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of p son who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registrar's 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BERNARD A TIMKO 11.19 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charlotte Hall Veterans ST. Mary 15 Charlotte Hall Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Country) Maryland Days 1 X M 2 □ F Hours (Month, Day, Year) 03/19/1920 90 Director 579-20-0964 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2X No Charlotte Hall Maryland St. Mary's 10e. Street and Number 10g. Citizen of What Country? è "natural", or items 23a o edical Examiner must be Funeral USA 29449 Charlotte Hall Road 20622 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? 1

✓ Yes 2 No þ 1 X Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Laborer U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Steven Timko Sarah Apperson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23140 Cobblestone La., California, MD 20619 Myles W. Timko/Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 09/22/2010 4 Donation 5 Other (Specify) Maryland Veterans Cheltenham, MD 21. Signature of Juneral Service Ligence
Edward N. Brinsfield, Jr. M00052 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Preumonia Physician, disease or condition resulting in death) 9/8/10 Medical Due to (or as a consequence of): Examiner 2007 homic obstantive Pulmonary Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ung and 2005 or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Liver mass and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical 2002 Adenocarcinome colon Division of Vital Records, P.O. Box 68760 NA attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month 9 Unknown detached our runeral unector. After this certificate has been signed by a completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Stemosis, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☑ No Other: 4 M Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 M Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Thibords MD. 9/16/2010 D0064324 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pme eme Santha , 100 Hospital Rd. Prince Frederick, mo, 20678 31. Date filed (Month, Day, Year) SEP 20 2010 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1-** State Registrar #15,22, per fh, 9/16/10 ca amend item Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Jear 2010 Physician/ GINGER FAE TARR 0914 M ptember Medical 4a. Facility Name (if not institution, give street and number County of Death 4b. City, Town, or Location of Death **Examiner** COMI Chineula Regional Medical ishul Date of Birth 9. Birthplace (State or Foreign **Funeral** 585-48-6395 1 M 2 🖼 F Months Min Country) 49 67 - 27 - 1961 Germany Director Usual Residence of Decedent 3a or 28a-f show t be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Funeral Director Md. Somerset 1 Yes 2 No Princess Anne 10e Street and Number 10f Zip Code 10g. Citizen of What Country? must be 10452 Pidgeon Lane, Princess Anne, Md 21853 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. "natural", or iterr ledical Examiner r 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ← No Specify: Specify: White Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) College (1-4 or 5+) Title Clerk Automobile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David Redden Rebecca Gaskill Tarr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy D. Tarr Husband 10452 Pidgeon Lane, Princess Anne, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Downing Cemetery 09-16-2010 Oak Hall, Va 22. Name and Address of Facility] 1673 Somerset Ave. Princess Anne, Hinman Funeral Home . Sign were of Funeral Service Licenses Princess Anne, MD 21853 Þ M00295 1. Enter the disease, or complications wat caused the death. Do not enter ock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final d Death Ph sician/ ase or condition Medical resulting in death) Examiner Sequentially list conditions it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a c Exami The law requires that the death certificate be executed and the burial-tran Due to (or as resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 Tes Yes To the Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending atural within 24 hours after death.

To the Funeral Director: A 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie

State Registrar (Check

3

29b. Signature and title of certifier

0 31. Date filed (Month, Day, Year,

ess of person who completed cause of death (Item 23a) (Type, Print

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Physician/ VOLTAGGIO SEPTEMBER 2010 \mathbf{E} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, 1 □ M 2 🔀 F Days Hours Min. Washington, DC Months 89 577-24-0851 1921 Director June Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10a, State 10c. City, Town or Location filed within 72 hours after death with the Maryland Funeral Director 1 Yes 2 X No Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9521 Dubline Road 21793 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. ıral", or iten Examiner ı Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify. "natural", 3 X Widowed 4 Divorced White Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than r traumatic event, the M Elementary/Seconday (0-12) 12 College (1-4 or 5+) Accounting Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file f Health and Mental item 27 is marked o ဂ Otis F. Hullings Laurette Marks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Voltaggio / Son 11397 Canary Drive, Ijamsville, MD 21754 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of I limportant: If ite any injury or of o = 0 1 🗆 Burial 2 ី Cremation 3 🗀 Removal from State 9/10/2010 Stauffer Crematory Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease or complications that solded the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure that only one cause on each line. Interval Between INFECTION Onset and Death Immediate Cause (Final TRACT Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): . Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or liniury and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) Pregnant at time of death 1 ☐ Yes ∠ ⊭ 9 ☐ Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown peen . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 death? 1 Yes 2 No 1 Yes 2 No this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🗗 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at s after death.
I Director: After the in by the funera Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined building, etc. (Specify) City or Town, State) 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2, To the F only one) 29b. Signature and title MD 2006/4/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOLL HOUSE AVE FREDERICK MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Bresien Registrar

31. Date filed (Month, Day, Year)

32. Registra s Signature

To Be Completed by Funeral Director

Physician /Medical

Examiner

Funeral Director

Physician/Medical Examiner

Be Completed by

Medical Certification: To

Plea	ase Type or Pr								∍gible.	
For State Registrar		,		ertment of He ertificate of De			Re	eg. No. 2	010	30762
1. Decedent's Name (First, Midd			_			L,	2. Date of Death Month	Day	Year	
		EAN WILLEY	Y	41. 00	20.51	25		6/2010	0	7:00 A M
4a. Facility Name (If not institution				4b. City, Town, or Lo				4c. Cc	ounty of Dea	cath CHESTER
2978 G 5. Social Security Number	REENBRIER RI	O. Age (In yrs. last birt	thdav)	If Under 1 Year I	AMBRID If Under 24 F	Hrs. 8	8. Date of Birth	14	9. Bi	Birthplace (State or Foreign
5. Social Security Number 216-38-9810	1 M 次 F		Yrs.			vin.	(Month, Day, 10/11/1	Year)	0	Country) MARYLAND
Usual Residence of Decedent							_ 0: 2 21			
10a. State 10b. County		10c. City, Town	n or Loc			_				10d. Inside City Limits 1 ☐ Yes ※ No
	ORCHESTER				MBRID	GE		Nr. 5	n = * * * * * * * * * * * * * * * * * *	
10e. Street and Number	GREENBRIER R	D.		10f. Zip Code	21613		1	ug. Citize	n of What C	Country? JSA
11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S.	13. V		panic Origin'	? (Spec	cify Yes or No-	14.	. Race - Am Black, Wh	merican Indian, hite, etc.
1 ☐ Never Married 2 ☐ Ma ③ Widowed 4 ☐ Divorce	arried 1 ∐ Yes 2) If Yes. Give	No No			Specify:	t	, 0001	Sį	Black, Wh	WHITE
15. Decede	ent's Education nest grade completed)		(Give F	dent's Usual Occupation		workin		16b. Kind	l of Busines	ss/Industry
Elementary/Secondary (0-12)		or 5+)	life. L	DO NOT use retired)				,	MANITIT	FACTURING
10				SHIPPING			(First, Middle, N			DRIMOLOLL
17. Father's Name (First, Middle HFR		Oblin or		1	. J. IVIOTNER'S	, vaine	•		urname) BBOTT	1
	RBERT RILEY N		Mair	ng Address (Street an	nd Numba-	y Bum'				
19a. Informant's Name/Relation BARBARA J. HAR		HTER		2978 GR		IER R	RD., CAME	BRIDG	E, MD 2	21613
20a. Method of Disposition	2 □□	cemeter	f Dispo:	sition (Name of matory or other place)					•	or Town, State
Marial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (ate	-	THODIST CHURCH CEMET	· .	9/30/2	2010	(CAMBI	RIDGE, MD
21. Signature of Funeral Service	na Lioc nsee		- 1	2. Name and Address	,			10-		Maria
23a. Part 1. Enter the disease,	-		-		-	_			н ST.,CA	AMBRIDGE, MD 21613 Approximate
shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to (or c.	as a consequence	of):	Pancient		-				Interval Between Onset and Death
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Moo 9 □ Unknowh	1 Live bir	ome of pregnancy th 2 □ Fetal death nt at time of death wn		☐ Ectopic pregnancy ☐ Other (specify)				23	3d. Date of o	delivery Day Year
Part II. Other significant condi	itions contributing to deal	th but not resulting i	in the u	nderlying cause giver	n in Part I.	_	23e. Did tol	. 42		e to the cause of death? Probably 4 Unknown
Embolism	OSTEOP	enia		,				med? 2 No	24b. Were prior death	
25. Was case referred to medic examiner?				Other	r.		(Check only on	né)	-	DALIGHTED'S HOMO
1 Yes 2 XIIIo			· · · -	nt 3 DOA Other	4 LI Nursi		me 5 Reside	ence 6	Occurred	DAUGHTER'S HOME Specify)
	stigation	, Day, Year)	Time of Injury	M 1 □ Ye	rat ? ∕es 2 □ No	0	28d. Describe h			
4 nomicide	ermined 286. Place of building	f Injury - At home, fa g, etc. <i>(Specify)</i>					City or Tow	(n, State)		r Rural Route Number,
29a. Certifier (Check only one) 1 Certify 2 Medic	ying Physician: To the beat Examiner: On the base and manne	sis of examination a	je, deat nd/or in	th occurred at the tim nvestigation, in my op	ne, date and pinion, death	place, occurr	and due to the ed at the time, of	cause(s) date and p	and manne place, and	er as stated. due to the cause(s)
29b. Signature and title of certif	7	>,0,		29c. License	461	5		9/3	signed (M	onth, Day, Year)
	on who completed cause			Print) amble S	57	CA	mbrid	ge	MI)
21 Date filed (Month Day Ves	2r) 20 D-	nistra®s Signature						7/		

State Registrar

JY.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Whyte Wayne Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Salisbur If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F 577-58-8658 1073171944 Washington, DC 65 **Director** Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Tes 2 X No Maryland Pocomoke City Somerset 10e. Street and Number 10g. Citizen of What Country? by Funeral 21851 8890 Courthouse Hill Road USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 Divorced 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Government auditor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Aileen Ardis Cromer L. Whyte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1318 Balsam St., St. Leonards, MD 20685 Michael Shyte/brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9/15/2010 Salisbury, MD Balisbury Crematory Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that the death certificate be executed use as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ξō Month Year Day Pregnant at time of death 2 🗌 No ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Completed by Hospital or Attending Physician; The law requires 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 100 To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Feath Date of injury (Month, Day, Year) 28a 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 2 🗌 No 1 Tes Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier *Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. d title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2010 Month Physician/ Margaret H. Ammons Witte 3:50 AM September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Salisbury Wicomico Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea 1 □ M 2 🏝 F Months Days Hours Min Delaware 87 **Director** 218-12-1309 Nov. Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1X Yes 2 ☐ No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Funeral items 23a 900 Booth Street 21801 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give and Mental Hygiene. Completed 3 Wildowed 4 Divorced white Year or Dates event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) County Government 11 Bookkeeper permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Norman T. Hastings Gertie E. Figgs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 513 Pine Bluff Road Salisbury, MD Judy Bowen (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stephens Cemetery 09-14-2010 Delmar, Delaware 22. Name and Address of Facility
Short Funeral
13 East Grove 21. Signature of Funeral Service Licensee Home Street Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant Unknown 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the inector, page 2 s autopsy performe 2 No 1 Yes **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Marmer of De th 28b. Time of 28c. Injury at work? 1 🔲 Yes Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer injury 1 Natural 5 Pending 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my existing states. Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Salisbury MD 21804

910 Easternshore Dr

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mahesha Thimmarayappa M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <u>7:15am [™]</u> Vasantha Ayilavarapu September 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore 103 Chargeur Road Reisterstown 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral (Month, Day, Year an. 13.1 1 □ M 2 🎇 F Months Days Hours Country) Director 49 Jan. India 112-90-9633 Usual Residence of Decedent or 28a-f show 10a, State 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 ☐ Yes 2 🌠 No Baltimore Reisterstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral items 23a 103 Chargeur Road 21136 India 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 K Married "natural", or b Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give Specify: 3 Widowed 4 Divorced Completed Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Schools 5+ Teacher Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o should be Venugopalarao Suryakumari Ayilavarapu <u>Kasavaraju</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr Department of Health an Important. If item 27 is any injury or other trau. Krishna Ayilavarapu Husband 103 Chargeur Road, Reisterstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date

cemetery, crematory or other place) Carroll Cremation, Ind.

Eline Funeral Home

Physician Medical Examiner

the attending physician hed for use as the burial

been signed by the should be detached

this certificate has

within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of

director,

Division of Vital Records, P.O. Box 68760

Physician/Medical

þ

Completed

Be

မ

Certificate:

Medical

sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed

E FEMALE

21. Signa

Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

23b. Was decedent pregnant

in the past 12 months?

1 Yes 2

9 Unknown

25. Was case referred to medical

29b. Signature and title of certifier

2 100

5 \square Pending

Investigation

6 Could not be

examiner?

27. Manner of Death

Natural

2 Accident

29a, Certifier

(Check

Suicide
Homicide

23a. Prt 1. Enter the shock, or heart fail Immedia ause (Final

disease or con

resulting in death)

1 Burial 2 X Cremation 3 Removal from State

4 ☐ Dopation 5 ☐ Other (Specify)

o Funeral Su

Due to for as a consequence of, Due to (or as a consequence of)

J. Wayne Osterling

east, or complications that couled the death. Do not enter the le. List only one cause on each line.

23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of injury (Month, Day, Year)

Certifying Physician: To the best of my knowledge, deat Medical Examiner: On the basis of examination and/or inv

3 Certifying Nurse Practioner: To the best of my knowledge

3 ☐ Ectopic pregna 5 ☐ Other (specify)

28b. Time of

consequence of):

23d, Date of delivery Ectopic pregnancy

9/27/2010

23e. Did tobacco use contribute to the cause of death? 1 Yes

Month

Day

Year

3 Probably 4 Unknown 2 10 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 Yes 2 X

Hampstead, MD

Approximate Interval Between Onset and Death

11824 Reisterstown Road

2	6. Place of Death (Chec	ck only one)	
DOA	Other: 4 Nursing H	ome 5 Residence	6 ☐ Other (Specify)
28c.	Injury at work?	28d. Describe how inju	ury occurred

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

ed at the time, date and place, and due to the d	cause(s) and manner as stated. and place, and due to the cause(s) and manner stated
occurred at the time, date and place, and due to	
29c, License number	29d. Date signed (Month, Day, Year)

M.D. qwe11 401 North Broadway BAltimore, MD 21231 Registar's Signat

1 Inpatient 2 ER/Outpatient 3 I

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1335 FP ZOID Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MARYLAND EDICK BACTIMORE UNIVERSITY OF MEDICAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. 314-84-6328 Balt. Maryland 44 Director January 22, Usual Residence of Decedent or 28a-f show notified at 10b. County 10a, State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Towson 1 ☐ Yes 2XXNo 10e Street and Number 10f. Zip Code ms 23a or 10g Citizene 6WhstCautes Funeral 728 Camberley Circle Apt. A7 21204 of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ı "natural", or iten edical Examiner r 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working Elementary/Seconday (0-12) Il Hygiene. College (1-4 or 5+) Goodwill Industries social service permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other to any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Thomas Martin Boyd Carolyn Bryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2141 Pine Valley Drive Timonium, Maryland 21093 Catherine B. Howard/ sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other place)
Evans Funeral Chapel—
Bel Air 1 Burial 2 X Cremation 3 Removal from State September Forest Hill, Maryland 4 Donation 5 Other (Specify) 26, 2010 21. Signature Funral Service Ligensee ²² Name and Address of Facilities Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner VERSES Sequentially list conditions, if any, loading to in mediate cause. Enter Underlying Cause (Disease or iinjury Examiner the attending physician and the for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed LEUKEMIA that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Yes 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed Yes 2 death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 X No Hospita Other: |2 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) D0069556 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

SWITH G-REDIE

CSE BALTIMORE, Md 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Anita Braun 651 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN Square Baltimore Hospital Rosedale Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**XX**F Months Days Hours Min. (Month, Day, Youst 19, Morefield, W 526-48-2044 Director August Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Harford Bel Air MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2511 Calary Road 21015 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Healthcare/ life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Shappard Pratt 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) Braun 18. Mother's Name (First, Middle, Maiden Surname) 2 Brad Compton Mame Dolan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2626 Mohawk Drive, Richmond, VA 23235 Nora Narum/Daughter Date 29, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Evans Funeral
Chapel – Bel Air Sept. 2010 1 Durial 2 X Cremation 3 Removal from State Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) Bel All 22. Name and Address of Facility Evans Funeral Cha 3 Newport Drive, Signature of Funeral Service Licensee Chapel & Cremation Services ve. Forest Hill, MD 21050 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between ediate Cause (Final Onset and Death Physician a Preumonia ise se or condition Medical re ulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Stage renal disease 1 Yes 2 No 3 Probably 4 Onknown Completed ATheroscier otic 24b. Were autopsy findings available prior to completion of cause of death? heart 24a. Was an has autopsy performed eral Director: After this certificate filled in by the funeral director, pag 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 🗆 Yes 2 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 2 ☐ Accident 3 ☐ Suicide 1 ☐ Yes 2 ☐ No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. D 69540 7 2010. 9 2

Registrar

DHMH 17 Rev 7/2009

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State

word. Rd Swib 204 Parkville MR 21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8413

0 1 2010

Shah

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend Items 23aPtI,25 per me,2908,10/01/2010dhb Registrar Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 8 Physician/ Month September 10 . 02 AM Trust Brown, 2010 Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AGINES HOSPITA Baltimore NA Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) 79 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
12-18-30 Social Security Number **Funeral** 1 🛛 M 2 🗆 F Days Hours 213-26-8791 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director items 23a or 28a-f s ner must be notified MD NA 1XXYes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2030 W. Fayette Street 21223 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, et African 11. Marital Status Armed Forces?

**XXYes 2 \sum No. "natural", or þ 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: American 1 ☐ Yes 2 🛛 No Specify: 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene.
7 is marked other than "r United States Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Postal Service NA Post Master Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည R. Brown, Trust Marion Weston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau June Brown-Sister 2030 W. Fayette <u>Avenue Baltimore, Maryland</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest 20a. Method of Disposition 20c. Location - City or Town, State Date XX Burial 2 ☐ Cremation 3 ☐ Removal from State 09-15-10 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore 23a. Fart + Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ a Hemorrhagic Shock secondary disease or condition Medical resulting in death) Due to (or as a c equence of): **Examiner** GEOW. Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last PROVED BY MEDICAL EXAMINER Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical CERTIFICAT IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) signed by the atter in the past 12 months? Pregnant at time of death Month Dav Year 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ dustunction 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 Yes 2 100 Vital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Division of Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 \square Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral C completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P25488 Susmita Sakruti september. 8th. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATON AVENUE BALTIMORE, MD Sakruti 9005 Susmita 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

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			1 - State of Maryland Dep State of Maryland Dep Registrar 25,27 per me,g908.1	artment of Healt 0/01/2010dhb rtificate of Deat	th and M th	lental Hyg	iene eg. N2 0	10	30769
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)			Date of Deat Month		Year	3. Time of Death
	Medic	cal	Thomas Albert Bennett			August	19 Day	2010	1:56 A ^M
	Examin	ier	4a. Facility Name (if not institution, give street and number) Gilchrist Center	4b. City, Town, or Locati	tion of Death		4c. Coun	ity of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Un	nder 24 Hrs.	8. Date of Birth		9. Birthp	lace (State or Foreign
	Director		219-32-5282 1 🕅 M 2 🗆 F 83 Yrs.	Months Days Hou	urs Min.	March I,	1927	Yorksh	Tre, England
	nd now at	٦	Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Lo	cation				1	0d. Inside City Limits
	larylar 3a-fsl ified	Director	Maryland Baltimore Towson					1	1 ☐ Yes 2 🔀 No
	or 28	١	10e. Street and Number	10f. Zip Code	_		I0g. Citizen o	f What Coun	try?
	s 23a ust b	Funeral	403 Far Hills Court	21286			U.S.A.		
	death item ner m		Armed Forces?	Was Decedent of Hispanic If Yes, specify Cuban, Mex				ace - America	
50	after al", or zami	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	1 ☐ Yes 2 🛛 No Spe	ecify:			^{ty:} White	
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yland	be file antal F ked o c eve	10 E	17. Father's Name (First, Middle, Last) Owen Bennett		nnie Same nnie Sam	(First, Middle, N	faiden Surnar	me)	
3	nould nd Me s marl umati			ng Address (Street and Nu			City or Town.	State. Zio C	'ode)
, Mar	d 2 stalth a			Pleasantville F					,
<u> </u>	of He of He item		20a. Method of Disposition 20b. Place of Disposition				20c. Location		wn, State
saltimore,	. Pag tment tant: jury o		The bullar 2 (A) Oremation 3 to Removal norm state	vice Corporatio	on 08/20,	/2010	Towson,	MD	
ga	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	2. Name and Address of Fa	acility Town	son, MD 2	1204	. D d	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent					K Koad	Approximate
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7	Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	ion a Hew	nowh	age			veics
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ŏ	r use	an/I	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	Ectopic pregnancy			23d. E	Date of delive	ry
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וומו	ian: T ertifica ctor, p	Be C	25. Was case referred to medical	26. Place of D	Death (Check		z ba Noj	1 103	2 🗆 110
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5	ding F h. After 1 funera	ate:	27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury	work?		8d. Describe ho	w injury occu	rred	:
VISION O	Attence r deatlector:	Certificate:	2 ☐ Accident Investigation 3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str			8f, Location (Str	eet and Num	ber or Rural	Route Number
2	al or safter		4 Homicide determined building, etc. (Specify)			City or Town			,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of Check 2 Medical Examiner: On the basic of examination and/or investigation.	occured at the time, date a	and place, and	due to the caus	se(s) and man	ner as stated	d. se(s) and manner stated.
	thin 2 thin 2 the F	Me	only one) 3 Certifying Nurse Practions. To the best of my knowledge, of 29b. Signature and title of certifier	death occurred at the time, o	date and place	, and due to the	cause(s) and r	nanner as sta	ted.
-	≒.≱ቴg		NO OH	29c. License number		2	9d. Date sign	ea (Ivionth, E	ay, rearj
			30. Name and address of person who completed cause of death (Item 23a) (Type, F	D 0070	7627		8/17	110	
				es St sui	ite 4109	Baiti	nove, k	17 21	Zal
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature	de l			- (-		
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		-	State Amend Item	n 25 State of Ma	ryland 908,1	Openart Of 01/20 Certif	ment of H) 10dhb icate of D	lealth and N Death	Mental Hy	giene _{Reg. N} 201	0 3077	0
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-	<u></u>		UNIVERSITY of 1 5. Social Security Number		OICAL (In yrs. last	FUTER I	BALT:	If Under 24 Hrs.	8. Date of Birt	h	Birthplace (State or Fo.	oreian
	Funeral Director		213-26-2226	1 XI M 2 □ F	60		onths Days	Hours Min.	June 12	, Year) 1950	Germany	
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	Maryla 28a-f s otified	Director	MD Prin	ce George's	La	urel	=				1 ☐ Yes 2 ∑	₹ No
	ith the		10e. Street and Number	Dead			10f. Zip Code 207(7.7		10g. Citizen of W	/hat Country? JSA	
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36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tier Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 🛣 Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes, Give	No	1	s, specily Cubar	n, Mexican, Puerto Specify:	Rican, etc.)	Black Specify:	k, White, etc. White	
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Maryland 21215-0036	iiled wi al Hygie I other vent, tl	Be	17. Father's Name (First, Middle,			COMP	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s		ne (First, Middle,	Maiden Surname)		
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Baltimore,	it. Page rtment rtant: I		4 Donation 5 Other ((Specify)	St.		Cemete		1/2010	Highlar		
Ba	permir Depar Impor any ir		21. Signature of Funeral Service	10 11	101103			tt Avenue			Home, P.A. 20707	ŀ
				or complications that caused only one cause on each line.	the death. [Do not enter th	. /				Approximate Interval Betwee Onset and Deat	
F	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	ACRA		/TEN	ORBITA	GE (2 DAYS)	Oliset and Deat	
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Division of Vital Records,	or Atter ter dea irector n by the	Certificate:	3 🔲 Suicide 6 🗆 Could		ry - At home . (Specify)	e, farm, street,	factory, office		28f. Location (S City or Tow		er or Rural Route Number,	
ā	To the Hospital or Attending Physician: The law requires that the within 42 hours after death. Of the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.		29a. Certifier 1 Certifyin	g Physician: To the best of r	my knowled	ige, death occ	ured at the time,	date and place, a	nd due to the ca	use(s) and manne	er as stated.	
	To the Hospital Mithin 24 hours a To the Funeral I completed filled	Medical	(Check 2 Medical only one) 3 Certifyin	Examiner: On the basis of ex ig Nurse Practioner: To the b	amination a	ind/or investiga	tion, in my opinio	n, death occurred a e time, date and pla	at the time, date a	and place, and due e cause(s) and ma	e to the cause(s) and manner inner as stated.	r stated.
			29b. Signature and title of certific	Box			29c. License				(Month, Day, Year)	
	(5)		30. Name and distress of person	who completed cause of de		3a) (Type, Print) ((/)	016//		10/10/	12010 UD 21201	
	-01-		GREGORY 31. Date filed (Month, Day, Year)	4. BASSMAN	r's Signatin	22	S. GRE	FUF ST	BALT.	tmore, A	1D 21201	
	Sta Registra		SEP 3 0 2	010 Semus	1.	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Physician/ Doris Brashears 1:10 A M 29 2010 Medical 4c. County of Death Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Homore OV Thwell 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Unde 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Country) MD **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "marked". 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State **Funeral Director** 1 Des 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Sori 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, 20b. Place of Disposition (Name of Method of Disposition Date Al from State Burial 2 Cremation 3 Ren cemetery, grematory or other 4 Donation 5 Other (Specify) eadow 21. Signature of Peral Service Lic 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Fh sician/ Bladder cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death been signed by the should be detached g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an cate has ; page 2 s autopsy death? After this certificate funeral director, pag 1 Yes 2 No Yes 21 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 4 - Nursing Home 5 - Residence 6 Dother (Specify) Hospital မ 1 Yes 2 🖸 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 Yes 2 No iniury 5 Pending Investigation in 24 hours give the further Euneral Director. Aft Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NJ Rajapahre M.D D0057465 9/29/10

State Registrar 28355 milh AV

32. Registrar's Signature

5-203,

Baltim at 1 MO. 21209 .

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapakse M.D

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Physician/ 2010 12:00PM Joyce Baer Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5456 Harpers Farm Road Apt#A1 Columbia Howard If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New York 1 M 2 X F March 23, 193 132-26-1845 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5456 Harpers Farm Road Apt#A1 21044 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Ş 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 ₺ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Employment Counselor State of New York Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Genevieve M. Battel Elmer C. Smith permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6261 Gilston Park Road Catonsville, Maryland 21228 Glenn R. Baer (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 9-29-2010 Glen Burnie, Maryland Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Eacility Witzke Funeral Homes, Inc 5555 Twin Knolls Road Co Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFARCTION Physiciani MYOCACDIAL disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death ed by the a 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed After this certificate funeral director, pag 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To I 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manpér of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 🗹 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No leral Director: A Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 29a) (Type, Print)

State Registrar AU, D

OCT 0 1 2010

31. Date filed (Month, Day, Year)

THOIS.

1N0

2. Registrar's Signature

5450 KNOU NORTH #250

Please Type or Print in Black Indelible hels / Ensure All Copies Are Legible.

			1- For State Registrar	Maryland / Depa	tificate of		u wenta		eg_No. 20	10 30773
Medi	Physic cal Exam		Decedent's Name (First, Middle,Last) Guy Raymond Bott	erill Ir	_			2. Date of Dea Month	th Day Year er 26, 2010	3 Time of Death 1400 hrs
	1		4a. Facility Name (if not institution, give st		41	b. City, Town, or	Location of I		4c. County o	
Section of the second	الميد		5502 Craig Avenue			Baltimore				
	Funeral Director		5. Social Security Number 6. Sex 217-24-8451 1XM	7. Age (In yrs. Ia	st birthday) 82 Yrs.	If Under 1 Yea Months Day		Min	3, 1928	9. Birthplace (State or Foreign Country) Maryland
	ny		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Locatio	in .				10d. Inside City Limits
	d how as	_	MD		altimor					1 ▼ Yes 2 No
	Maryland 28a-f show d at nnce.	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	21
	with the Maryland ns 23a or 28a-f sho be notified at nnce	ä	5502 Craig Avenue			2:	1212		USA	
	led within 72 hours after death with the Maryland Jygiene. other than "matural", nr items 23a or 28a-f she the Medical Examiner must be notified at nnce	Funeral	1 X Never Married 2 Married	2. Was Decedent Ever in U.S Armed Forces? X Yes 2 No	If Ye	s, specify Cubar	n, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	White	
	urs aft. tural" tmine	호	15. Decedent's Education (Specify only I	Dates:		Yes 2 X No s Usual Occupat		d of work done	Specify: 16b. Kind of Bus	white iness/Industry
,,	led within 72 hou Hygiene. other than "nat the Medical Exa	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		st of working life				,,
20	within 72 iene. er than Medical	ğ	12	0	prin					employed
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212	should be fill and Mental F 7 is marked	To Be	Guy Raymond Botter 19a. Informant's Name/Relationship (Type		19b. Mailing	Address (Stree		h Louise S er or Rural Route Nur		. State, Zip Code)
Z	and 2 should lealth and Mertem 27 is mar	Π	Joan Churn/cousin		4.1			Joppa, MD	21085	
			20a. Method of Disposition 1 XX Burial 2 Cremation 3		lace of Dispositi		metery,	Date	20c. Location -	City or Town, State
Ë	Page ment o		4 Donation S X Other Specify:	n state Me	oreland			10/04/2010		ille, MD
Baltimore	permit. Pages 1 Department of F Important: If injury or other		21. Signature of Funeral Pryice Licenses	Director	50	ite anat	CHILD OF	McComas Fi	Daitin	
Р	hysician		23a Parti. Enter the disease, or complica	(MC	Do not enter the	timore, mode of dying.	MD 2	21201 1317 diac or respiratory arm	Cokesbui est. shock, or hea	ry RD. 21009
	'Medical xaminer	E 72	failure List only one cause on each Immediate Cause (Final disease a Hy	line. pertensive Atheroscle e to (or as a consequence of)	erotic Cardio					Between Onset and Death
		L	Sequentially list conditions, b							
		miner	cause. Enter Underlying Cause	to (or as a consequence of)):					
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Q	spital hours and recal	Cer	4 Homicide determined	(Specify)					, <u> </u>	
	To the Hospital nr A within 24 hours after To the Funeral Dire completely filled in b	Medical	one) Certifying Physician: Wedical Examiner: On	To the best of my knowledge the basis of examination and	e, death occurre d/or investigatio	d at the time, da n, in my opinion,	ite and place , death occur	, and due to the caus red at the time, date	e(s) and manner a and place, and du	as stated e to the cause(s)
	F % F 8	Me	29b. Signature and title of certifier	d manner stated.		29c. License	e number		29d. Date signe	d (Month, Day, Year)
			(Salofell	W		O.C.I	И.Е.		September	27, 2010
6			 Name and address of person who com- Laron Locke MD. Assistant 		^{23a)} 111 Penn S	Street, Baltin	nore, MD	21201		
	Si Regis	tate trar	31. Date filed (Worth, Day 2010	32. Registrar's Signature	bare					

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death MONTGOMERY DLNET MONTGOMERY GENERAL HOSPITA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
March 26,1920 New York 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 X F Director 90 134-12-6630 Usual Residence of Decedent or items 23a or 28a-f show build be filed within 72 hours after death with the Maryland d Mental Hygiene.

marked other than "natural", or items 23a or 28a-f shor 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 🗌 Yes 2 🂢 No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20853 15204 Carrolton Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Government permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other tany injury or other traumatic event, the ODE. Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Emily Bennett John Ford Zogg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Thomas / Daughter 4312 Sir Walter Road, Olney, Maryland 20832 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 20. cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery 2010 Arlington, Virginia of Funeral Service Vicensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland M01305 23a. Part 1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) LHOLED Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Pregnant at time of death 9 Unknown g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by NSTEMI 2 No 3 Probably 4 Unknown 1 🗌 Yes DIABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After completed filled in by the funer. L Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D59418 to aurenor, mo SEPT. 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLUYEWISI ADEWUNMI, MD ADEWUNME, MD MONTGOMERY GENERAL HOSPITAL State

DHMH 17 Rev 7/2009

Registrar

racke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept. 28, 20TO Eileen R. Bates 9:25 ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General 01nev Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 M 2 XF Country) Director 213-42-6128 DC 86 1/15/192/ Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any higury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Tes 2 No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3510 Forest Edge Drive #1F 20906 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 XXVo 3 ➡ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Shea Mable Waugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Bates. 12614 Laurie Dr. Silver Spring, MD 20904 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State Chesapeake Crematory 9/30/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 21. Signat e Funeral Service Licensee M Silver Spring. Gist Ave. MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician, disease or condition resulting in death) 26 Medical Due to (or as consequence of): Examiner 00 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to lo The law requires that the death certificate be executed Cause (Disease or iinjury 2010 attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) Year led by the a Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed certificate To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral F. 2 🗌 No 1 🗌 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Natural iniury 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29c. License numbe H63912 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

31. Date filed (Month,

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State

Registrar
DHMH 17 Rev 7/2009

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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Amber Sue Bra	dy wi	fe)				17331
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building, etc. (Specify) City or Town, State) 29a. Certifier (Check 2 Medical Examiner: Of he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: Of he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 Certifying Narse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Huzefa Bahrain 9110 Philadelphia Road Suite 314 Baltimore, MD 21237 State	/ita	siciar s certif	o Be	examiner?	2/0-++	LOH!	ner:	,		- 🗆	
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building, etc. (Specify) City or Town, State) 29a. Certifier (Check 2 Medical Examiner: Of he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: Of he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 Certifying Narse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Huzefa Bahrain 9110 Philadelphia Road Suite 314 Baltimore, MD 21237 State	on	eath. or: Aft the fur	fica	2 Accident Investigation	irijury			10			
29a. Certifier (Check 2 Medical Examiner: Of he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: Of he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 Certifying Narse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who/completed cause of death (Item 23a) (Type, Print) Dr. Huzefa Bahrain 9110 Philadelphia Road Suite 314 Baltimore, MD 21237 31. Date filed (Month, Day, -Year) 32 Pesistrar's Signature	Oivis			4 Homicide determined 28e. Place of Injury - At home	e, farm, stre	et, factory, office		28f			ıral Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pr. Huzefa Bahrain 9110 Philadelphia Road Suite 314 Baltimore, MD 21237 State 31. Date filed (Month, Day, -Year) 32. Date filed (Month, Day, -Year) 33. Date filed (Month, Day, -Year)		he Hospit in 24 hour he Funera pleted filk	Medica	Check 2 ∟ Medical Examiner: On the basis of examination a	nd/or investi	gation, in my opin	ion, death occu	urred at the	time, date and	place, and due to the	cause(s) and manner stated.
30. Name and address of person whole empleted cause of death (Item 23a) (Type, Print) Dr. Huzefa Bahrain 9110 Philadelphia Road Suite 314 Baltimore, MD 21237 State 31. Date filed (Month, Day, -Year) 32. Pesistrar's Signature		To 1 With To t		29b. Signature and title of certifier				73	29	d. Date signed (Mont	h, Day, Year)
State 31. Date filed (Month, Day,-Year) 32 Pesistrar's Signature		2				rint)	-		imere	MD 21227	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician .58 A M Scotento 26 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AC 1361 nos to Spite more If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Jane 1 Months Days Hours 1 M 2 □ F 2/5-40-7045 Usual Residence of Decedent Director the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits show Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho, any injury or other traumatic event, the Modical Examination and to other traumatic event, the Modical Examination and the modified at Balto. 1 dres 2 □ No ha **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country with 4213 2/221 death 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No þ Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) renanc 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Crocke ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number Euclid 9211 E 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) natural of Funeral Service Licer 1701 Part 1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or all a consequence of): Examiner Decintizus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical ast IF FEMALE: asn If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. I ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Vital Records, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? Mel1,1 24a. Was an certificate has autopsy performed? 2 🗆 No 1 ☐ Yes 2- No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **₫₩**0 Certification: To 1 Appatient 2 ER/Outpatient 3 DOA Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 26 2010 By Hims-c 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 65KU VUD 21729 egistrar's Signatu State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28,2010 Physician/ Sept. Melicia C. Chase 03p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Stella Maris Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country). Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Days Hours Min (Month, Day, 1 🗆 M 2 🔀 F 219-76-1184 52 Director Sept. Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location than "natural", or items 23a or 28a-f sho the M dical Examiner must be notified at 10d. Inside City Limits Director N/A MD Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? with items 23a Funeral 1121 Sara Ann Street 21217 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc 1X Never Married 2 ☐ Married <u>۾</u> Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Forklift Operator Industry 12th N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Levin W. Chase Elva Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is SEPTEMBER Yvette Chase/Sister 301 Romaric Ct. Baltimore, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State any injury or 10/4/10 Lansdown, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beverly D. Cromartie F/S Signature of Funeral Service Licenses 2700 Edmondson Ave. Balto., me, 10 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ BREAST CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burial-1 attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Dav Year 5 Other (specify) ed by the 9 Unknown Division of Vital Records, P.O. CHASE Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Hospital or Attending Physician: The law require: 24 hours after death.

Funeral Director; After this certificate has been signed filled in by the funeral director, page 2 should be ted filled in by the funeral director, MELICIA Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performed? Yes 2 **X** No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🗶 No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d, Describe how injury occurred 1 X Natural iniury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours af

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

X Certifying Nurse Practioner: To the best of my knowledge death occurred at the time, date and place and due to the cause(s) and manner stated. (Check only one 29b. Signature and the of certified 29c, License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 1 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23a&23PII PER PHY G909 11/04/10 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 28 Physician/ Julia K. Callan 2010 September 8:30 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9 Chapel Court Baltimore Timonium If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min April 26, Year 919 Balt., Maryland 213-26-6311 91 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Baltimore Towson 1 Yes 2XXNo 10e. Street and Number United States of America 10f. Zip Code ò Funeral 21286 with 23a 608 Lake Drive items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 is marked other than "natural", or ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Catherine Doemling John Krejci or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, Maryland 21286 Mr. John D. Callan/ husband 608 Lake Drive 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Examples, seamatory of other place) Chapel-Bel Air September 29, 2010 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licensee Remarkable Addition of Fundamental Addition Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part V. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. - Metastatic Adinocarcinoma (Unknown Immediate Cause (Final disease or condition) Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine ii any, leading to immediate cause. Enter Underlying Cause (Disease or linjury pue to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the luneral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Noninvasive Bladder Cancer Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital: 6 Other Specify Residence မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 7010 20649 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IDWSOR. 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 24, Physician/ 2010 3:04 PMM Israel Collins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 9106 Pineview Lane Clinton 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Hours 1926 1 💢 M 2 🗆 F Alabama 83 421-22-5442 **Director** Dec Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Prince George's Clinton 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 9106 Pineview Lane 20735 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 14. Race - American Indian, 11, Marital Status Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: black Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hourment of Health and Mental Hygiene. ant; If item 27 is marked other than "natu ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) dry cleaners self employed n Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Annie Lee Riles Israel Collins Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 917 Manor House Drive Upper Marlboro, MD Harriett Collins/daughter 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department 4 ☐ Donation 5 ♥ Other (Specify) in state Sign xure of Fune al Service Licensee R nald S. W 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Year Pregnant at time of death page 2 should be detached Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 XN within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 X No Certificate: To 1 冢 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined To the Hospital Medical ▲ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 29b. Signature and title of certifier

State Registrar LINE CENTER WALDONF.

of person who completed cause of death (Item 23a) (Type, Print)

2070

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10c, 20c, perFH, G908, 10/14/2010, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2010 Margaret September Congleton 30 04:09 PM Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oak Lodge Assisted Living Pasadena Anne Arundel Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth A (Month, Day Year) A u g · 29 1931 Funeral 9. Birthplace (State or Foreign Days 1 🗆 M 2 🖼 F Months Min. 218-26-4610 Country) Director 79 Yrs. MD Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Pasadena Maryland 1 Yes 2 No Anne Arundel 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. 23a 195 Hickory Point Road 21122 USA items 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☒ No Specify: 3₺ Widowed 4 Divorced Specify White Completed is marked other than "naturaumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Household Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lawrence Strassner Sophie Brecht 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i other tra John W. Congleton, 111 (son) adena MD 21122 195 Hickory Point Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Oct. 04 Brooklyn 4 Donation 5 Other (Specify) Cedar Hill Cemetery Brook Tynn, 2010 Maryland of Funeral Service License 21. Signature 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road Pasadena, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of). Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown been signed by the atte should be detached for in the past 12 months?

1 Yes 2 No 5 Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s autopsy performe this certificate Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certific Division of Vital 25. Was case referred to medical filled in by the funeral director, To Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Spec 1 Inpatient 2 I ER/Outpatient 3 I DOA ASSISTET Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work 1 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed within 2 only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ertifier 29b. Signature and title of 29d. Date signed (Month, Day, Year) D0002415 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CICHAR State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 21 State of Mandand (Department of Health and Mental Hygiene For A State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 19, Physician/ Sr. 7:30 a M Crowder 2010 Lee Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore** Hospice Richey Joseph 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** NC 1 X M 2 □ F Days Hours 75 1171171934 245-46-0386 Yrs. **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State be filed within 72 hours after death with the Maryland Director BALTIMORE MD 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 Funeral **4918 ABERDEEN AVENUE** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 M Married Completed by 21215-0036 1 ☐ Yes 2 🔀 No **Black** 3 Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bethleham Steel Steelworker 5 4 1 9th nd Mental Hygier marked other t Be land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sassafras ပ Airey Crowder Lee . Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4918 Aberdeen Avenue, Baltimore, MD 21206 19a. Informant's Name/Relationship (Type, Print) Mildred Crowder - wife Baltimòre, 20c, Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite cemetery, crematory or other place)

Dulaney Valley Cem. 1 X Burial 2 Cremation 3 Removal from State Baltimore, MD 09/24/2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Funeral Services 21. Signature of Funeral Service Licensee 4905 York Road, Baltimore, MD 21212 George Spears per dvr 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final etastati Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (of as a consequence of). Exami g physician and as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Box in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown the g Unknown signed by the Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ō. Be Completed by 2 No 3 Probably 4 Unknown 1 Yes Division of Vital Records, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe las l certificate | 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No SRICE မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA after death. Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔼 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral C

completed filled Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 201

Registrar

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State

9)

30. Name and address of person who completed cause of death (Item 23a) (Type, Pri

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 29,2010 Physician/ D Caroline Cook Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore <u>Greater Baltimore Medical Center</u> Towson 7. Age (In yrs. last birthday) 76 yrs. 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 - M 2 - XF Hours october 216-1933 219 30 9002 Baltimore, Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland Director or 28a-f st notified Baltimore County 1 Tes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò er than "natural", or items 23a on the Medical Examiner must be Funeral 21236 LISA 4558 Ridge Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. ģ 1 Never Married 2 Married Yes 2XX No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Completed 3X Widowed 4 Divorced Year or Dates. White 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Maryland Schoolfor the Blind Care Taker is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be filed 17, Father's Name (First, Middle, Last) Violet Kathryer ၉ Albert Winfield Kirby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3501 Taylor Avenue Baltimore, Maryland 21236 19a. Informant's Name/Relationship (Type, Print) Katherine L. Cook Department of Health Important: If item 27 injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State Metro Cremetory Inc September 30 2010 Baltimore Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassann Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the dimase, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Ons and Death Immediate Cause (Final disease or condition Physician/ chino, o bara) Medical resulting in death) Due to (or as a consequence of) **Examiner** coa culation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a sequence of) atria To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury nronic that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death been signed by the a should be detached t g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? þ adenocarcinomo Paragi 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an iis certificate has director, page 2 s autonsy performed? Concestive 1 Yes 2 No neart 25. Was c referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ည 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2090 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Stroot 670 narie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Baltimore,	ゼモモラ		21. Signature of Funeral Service License				haddeson Farill	y Fun		ternati	ves	
m	permi Depar Impo any ir		Rebecco &	Journa Moiso	3	8717	Green Pas	sture	s Drive	Towson	Maryl:	and 21286
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~-F	h sician/	N 1	Immediate Cause (Final disease or condition	a. AEJTE P Due to (or as a consequence b. ATHEPOSEL	1400	APDI	AL IN	JF4	PCTIE	N		Onset and Death
المبيد	Medical Examiner		resulting in death)	Due to (or as a consequent	eno of):		//			4 = 4	_	
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	ence of:	ric	CHRDIOVA	4200	LAK D	(>54>		
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury									
	ath certificate be executed attending physician and for use as the burial-transit	_	that initiated events resulting in death) Last	Due to (or as a consequent	ence of):							
	e be o	Physician/Medica	_	d								
87	tificat ing ph as th	Med	IF FEMALE:									
9 ×	th cer ttendi	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar	death 3	☐ Ectopic p				23d	. Date of deliv Month	ery Day Year
B	e dea the a thed f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	eain 5 L	□ Other (st	leary)					
P.O. Box 68760	es that the des signed by the a I be detached f	by Pr	Part II. Other significant conditions co	entributing to death but not resu	ılting in the u	underlying (cause given in Part	I.	23e. Did t	obacco use o	contribute to t	ne cause of death?
, l	uires 1 n sigr uld be	q pa	1						1 🗆	Yes 2 🗆 N	lo∵3□Pro	bably 4 Unknown
000	w require s been si 2 should	Completed							24a. Was		4b. Were auto	psy findings available impletion of cause of
3ec	he la Ite ha	om							perfo	rmed?	death?	
a	sician: The law is certificate has but incector, page 2 s	Be C	25. Was case referred to medical examiner?				26. Place of Dear	th (Chec				
₹	Physic this ce ral dired	D T	1 Tes 2 No	lospital:			Other: 4 Nu	ursing Ho	ome 5 Resi	dence 6 🗌	Other (Specify)
J Of	ing P	ate:	27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury		8c. Injury at work?	, ,	28d. Describe I	now injury oc	curred	
ior	l or Attending after death. Director; After I in by the funer	Certificate:	Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		ne farm etr	M eet facton	1 Yes 2	No	28f Location /	Street and No	imber or Rura	l Route Number,
Division of Vital Records,	al or A s after al Direct		4 Homicide determined	building, etc. (Specify)		001, 140101	, 01100	ļ	City or Tov		armoor or riare	Thous Hambon,
	Or the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the buse.	Medical	(Check Z Medical Exami	ician: To the best of my knowle ner: On the basis of examination e Practioner: To the best of my	and/or inves	stigation, in	my opinion, death oc	ccurred a	t the time, date a	and place, and	d due to the ca	use(s) and manner stated.
	To the P within 24 To the F complet	-	29b. Signature and title of certifie	1/			License number			29d. Date si	gned (Month,	Day, Year)
			Key4(M.D.			リングじ	33	· _	SEPTE	MBER	28,2010
			30. Name and address of person who c	/			- 4 - (L =			28,2010
			31. Date filed (Month, Day, Year)	ZPH M.D. 59	601 4	och_	RAVEN	BL	VD B	LUTIN	GPE, A	W 41299
	Sta Registra		OCT 0 1 2010		back	/						

DHMH 17 Rev 7/2009

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State Registrar

ORIGINAL

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death P 2 Date of Death Month 9 2010 **Physician** ATALINA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bultmore
If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (În yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Days 1 M 2 TXF Yrs. 77 Director 218-28-2995 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itsm 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event. The Madical Examinar must be notified at Director 1 ☐ Yes 2 → No Baltimore Randallstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9714 Kerrigan Court 21133 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Library and Mental Hygie is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Fernando Guzman Katherine Schnuit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Edward M. Davis (Son) 1670 Pin Knob Rd., Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō <u>=</u> 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ö Department important: if any injury o Lake View Mem. Park 10/5/2010 Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee Man PO Box 195 Sykesville, MD 21784 M00764 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. UNG Anset and Death Immediate Cause (Final CANCER Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, I any, leading to inimicaliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). ettending physicien and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 1 ☐ Yes 2 X No Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Magner of Death 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Naturai 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and tipe of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST AGNES 900 BALTIMORE MD 21229 CATON AVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2 0 1 0 3 0 7 8 9 State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	State of Maryland		ate of Death			eg. No.	
Physician/	1. Decedent's Name (First, M					2. Date of Dea Month	Day Year	3. Time of Death
Medical Examine	dean dibson			Ab City To	wn, or Location of		er 16, 2010 4c. County of Deat	0000 hrs
	4a. Facility Name (if not institute 600 North Wolfe St		,	Baltim		Death	40. County of Deat	
Funeral	5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birth	nday) If Under	1 Year If Under	24Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Bi	
Director	578-28-7738 Usual Residence of Decedent	1 M 2 X F	84	Yrs. Months	Days Hours	May 10), 1926 Forei	ou Ma) ryland
any	10a. State 10b. Cour	ty	10c. City, Town	or Location		-		10d. Inside City Limits
und show ace.	Virginia Fau	quier	Remin	gton				1 Yes 2 X No
Maryls 28a-f d at o	10e. Street and Number		<u> </u>	10f. Zip 0	ode	1	0g. Citizen of What Cou	intry?
th the 33 or rotifie	11741 Freeman				2734		U.S.A.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2	Married 12. Was Decedent Armed Forces'	?			n? (Specify Yes or No Puerto Rican, etc.)	14. Race - Amer White, etc.	rican Indian, Black,
fter de I", or IEF INI	3 X Midowed 4	1 Yes 2 Divorced If Yes, Give Year	X No	1 Yes 2	No specify:		Specify: Bla	ck
iours aft	15. Decedent's Education (S	pecify only highest grade cor		Decedent's Usual O			16b. Kind of Business	Industry
5-0036 ed within 72 hour yygiene. other than "natu the Medical Exau Completed	Elementary/Secondary (0-1	2) College (1-4 or	5+)			ise retired/	,	
d withingiene ther the Med	9 17. Father's Name (First, Mide	le. Last)		Domesti		Name (First, Middle, N	Private F	amily
215 be file ntal Hy rked o ent, th		,				ie Gibson		
D 21 hould od Mer is man itic ev	19a. Informant's Name/Relation		0.7		-		nber, City or Town, State	
ME and 2 slath ar sm 27	Ronald A. Gib	son (Son)		741 Free		d Rd., Remi	ington, VA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other transmatic event, the Medical	1 X Burial 2 Crema	ion 3 Removal from St	ate cremato	ory or other place)		9/27/10		
Itim ii. Pa urimen ortant y or o	4 Donation 5 Other 21. ignature of uneral Serv		Culpe	per Nat'			Culpeper,	VA
Balt permit. Departi Import injury	1 Journ	Allin		Joynes P.O. B	Funeral	Home, Inc Warrenton	. VA 20188	4
Physician	23a. Part I. Enter the disease, failure. List only one cau		the death. Do not					Approximate Interval Between Onset and
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ner	Sequentially list conditions, if any, leading to immediate cause. Enter the entrying Cause	Due to (or as a cons	equence of):					
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760, critical be executed the burial - transit		d						ļ
760, ate be execu physician and he burial - trz	UNPENDED	AMENDED					1004 044 4 445	
1876 rtificat ing phy as the	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 23c. If yes, outcome the Live birth	me of pregnancy 2	Fetal death	3 Ectopic p	oregnancy	23d. Date of deliver Month	y Day Year
). Box 687 the death certific by the attending p ched for use as the	1 Yes 2 No 9	Inknown 9 Unknown	time of death 5	Other (Specif	(v)		1	
D. B true de by the ached t			h but not resulting	in the underlying o	ause given in Part	1. 23e. Did to	bbacco use contribute to	the cause of death?
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Records, The law requires ficate has been significate been significate been completed Completed						24a, Was a autop		utopsy findings available completion of cause of
tecc The lav ate has							rmed? death?	
Vital Rec ysician: The l his certificate I director, page	25. Was case referred to med examiner?			26	.Place of Death (C	Check only one)		
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vision of ' or Attending Ph firer death. Director: After t in by the funeral iffication: T	1 Netweet	28a. Date of Inju (Month, Day) Sep 16, 2010	(ear) 200. 1 1111		c. Injury at Work? 1 Yes 2 ✓ N	Subject shot	now injury occurred t	
rision r Atten er death rector: n by the	2 Accident In	vestigation	njury - At home, far	m, street, factory, o		-	Street and Number or Ru	ıral Route Number, City
Division o spital or Attending tours after death. neral Director: After filled in by the func Certification:		termined (Specify) Ho	spital			or Town, S 600 Wolfe Str	itate) eet, Baltimore, MD	
2 2		Physician: To the best of m						
To the Ho within 24 To the Fu completel	29b. Signature and title of cert	and manner stated.	mination and/or in		_icense number	arred at the time, date :	29d. Date signed (Mo	
2	July Organization and united of Cert	1 1 1	4		O.C.M.E.		September 17, 2	
2	30 Name and address of pers	on who completed cause of o	leath (Item 23a)					
	Zabiullah Ali, M.D.	Assistant Medical Ex	xaminer 11	1 Penn Street,	Baltimore, Mi	D 21201		
State Registrar		32. Registra	Signal Signal					

			State of Maryland / Dep				30790	
	Registrar 1. Decedent's Name (First, Middle, Last)			rtificate of Death	2. Date of Dea	rieg. No. 0		
Phy	ysicia	n/			Month Sept.	Day Year	3. Time of Death	
Medical Examiner			Mary E. Waller Donkoh 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		17, 2010 0050 M		
	Prince Georges Hospital Center			Cheverly		Prince G		
Fur	neral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)			n 9. Bir	thplace (State or Foreign	
Dire	ector		227-15-7291 1 M 2X F 42 Yrs.	Worth's Days Hours Will.	March 9	,1968 V	irginia	
pu	at .	١	Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits	
anylar	fied	Director	MD Prince Georges Sur	itland			1 X Yes 2 ☐ No	
the M	e not	ä	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	ountry?	
with with 23a	nst p	Funeral	2202 Gaylord Drive	20746		USA		
Jeath Items	er m		11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame		
36 after of	camir.	<u>a</u>	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 🕱 No Specify:	7 110411, 0101,	Black, Whit	le, etc. Slack	
	la L	Completed	3 Wildowed 4 A Divorced Year or Dates.					
72 h	Medic	현	(Specify only highest grade completed) (Give	edent's Usual Occupation hind of work done during most of wor DO NOT use retired)	king	16b. Kind of Business	Industry	
212 vithin jiene.	鲁		Elementary/Seconday (U-12) College (1-4 or 5+)	Cashier		Private I	ndustry	
land 21215-0036 be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 28a or 28a-f sho	vent,		17. Father's Name (First, Middle, Last)	18. Mother's Nar	ne (First, Middle, i	Maiden Surname)		
Vlan d be fil Mental arked g	matic event, the Medical Examiner must be notified at	잍	James M. Waller	Mattie	Jones			
Baltimore, Maryland 21215-0036 Demit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. If Item 27 is marked other than "natural"; o	traum		19a. Informant's Name/Relationship (Type, Print) Charlene Waller/Sister 19b. Mai 2202 Suit	ing Address (Street and Number or Ru. Gaylord Drive and, MD 20746	ral Route Number	; City or Town, State, Zi	ip Code)	
re, 1 and f Heal item	othe		20a. Method of Disposition 20b. Place of Disp	osition (Name of	Date	20c. Location - City or	r Town, State	
IMOF Page 1 nent of ant: If it	ry or		1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Church Cemeters of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contr	avery Baptist emetery 9/2	5/10	Ivy. VA		
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tal cian: ertific	ector,	Be (25. Was case referred to medical examiner? Hospital:	26. Place of Death (Chec	ck only one)		-	
Physic This c	al dire	٥,	1 No 1 Partient 2 L ER/Outpatie		1	ence 6 Other (Spec	cify)	
Division of Vital Records, tal or Attending Physician: The law requires rs after death.	e funer	Certificate:	27. Manner of Death 1 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) injury	28c. Injury at work? 1 Yes 2 No	28d. Describe h	ow injury occurred		
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DIV talor is after al Dir	ed in		building, etc. (Specily)		City or Tow	n, State)		
DIVISION Of VITAI Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate h	completed filled in by the funeral director,	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or inve	stigation, in my opinion, death occurred	at the time, date ar	nd place, and due to the	cause(s) and manner stated.	
o the	эм	Σ	only one) 3 L Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, date and pla 29c. License number		cause(s) and manner as 29d. Date signed (Mont		
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	,		30. Name and address of person who completed cause of death (Item 23a) (Type,					
	\		mukemil Abdella,	on				
Re	Stat	e	31. Dance (Nonto, 20 Year) 32. Registrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death September 29 Physician/ 2010 11:05 Deanna Marie Doheny Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) August 13, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 🗆 M 2 🕱 F 1954 Pennsylvania 56 Director 179-40-9131 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 ☐ Yes 2 X No Potomac Maryland Montgomery 10f. Zip Code ö 10e Street and Number 10g. Citizen of What Country? ms 23a or must be n Funeral 12 Pettit Court 20854 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. "natural", or item ledical Examiner r 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Je filed wh...
Jental Hygiene.
God other than "r
" of other the Mr (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anna Godoti Virginia Todeschini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Pettit Court, Potomac, Maryland 20854 Noel Doheny/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, October 2, 2010 Germantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) All Souls cemetery Signature of Funeral Service Licensee R^{22 Name and Addrass of Facility} Robert A. Pumphrey Funeral Home, Chevy Chase Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 Haran M01530 7557 Wisconsin Avenue, Bethesda, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Acute Pulmonary Embolus disease or condition resulting in death) Medical Medical Examiner Metastatic Breast Cancer Invading Into Pulmonary Artery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events ne Due to (or as a consequence of) Exami requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 X No Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 should be 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law has autopsy page performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗶 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 X No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 \square Pending work X Natural after death. 1 🔲 Yes 2 🔲 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) npleted filled in by 4 Homicide 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I Signature and title of certifier September 30, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9404 Old Georgetown Road, Bethesda, Maryland 20814 Gita Bakshi, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 01 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Richard Joseph Donahue 3:06 PM Sept 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Towson <u>Baltimore Co.</u> 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. (Month, Day, Year, ountry) 1 ☑ M 2 🗆 F **Director** 213-26-087 20, 1930 Maryland Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland event, the Medical Examiner must be notified at Director 1 Yes 2 X No MD Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3206 Everlasting Lane 21220 <u>United States</u> permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked others any injury or others? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates White 3 - Widowed 4 - Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Fire Fighter Fire Department <u>ll Years</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas Reda Cavey Donahue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Emma V. Donahue (Wife) 3206 Everlasting Lane Middle River, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 NOther (Specify) Entombat #611v Hill Mem. Gdns. 10/2/2010 Middle River, MD 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death shock, or heart failure. List only one causa Immediate Cause (Final Physician/ Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 ponths? Day Year 5 Other (specify) Pregnant at time of death g Unknown □ Unknowi signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Hospital Other: ျှ 1 🗌 Yes 2 🔽 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1 Natural iniury 5 Pending Investigation Accident after death 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 124 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar 29b. Signature and title of certifie

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Si

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 Robert Guy Evans Septembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Union Hospital E1kton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Feb 10, Year) 28 West Virginia 1 X M 2 □ F Months Days Hours Min. Director 82 233-38**-**9677 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No E1kton MD Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 USA 106 Decker Street 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. δ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify If Yes, Give Specify: white Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than College (1-4 or 5+) 0 autoworker transportation Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Clarence Theodore Evans Mary Martha Hager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Glenn Evans/son 187 Jefferson Road Salem, NJ 08318 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important; If ite any injury or oth 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Signation of Euneral Solvice 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street timore, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** equentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of use as the burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🗆 Yes icate has been siç ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Yes 2 N completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 1 No 1 Denpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28c. Injury at 28a. Date of injury 28h Time of 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work 1 Tes 2 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death 2100PM **Physician** 9 22 Irvin Finney 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore FRANKLIN Square Hospital Rosedale 7. Age (In yrs. last birthday)

69

Yrs.

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12/15/1940 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral †** M 2□ F 220-38-7310 **Director** Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinant out be notified. 1XYes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 152 Akin Circle 21220 by Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 XNever Married 2 ☐ Married 1 □Yes 2 No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2**X**☐ No Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11th Grade Mover Stewart Kitchens 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Finney Vonzella Jackson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bernard Jackson(brother) 2904 Reisterstown Rd., Baltimore, MD 21215 20b. Place of Disposition (Name of femalery, crematory or other place of Disposition (Name of femalery) and Crematory 20c. Location - City or Town, State 20a. Method of Disposition 09/28/10 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, MD 4 □ Donation 5 □ Other (Specify) ²² Name and Address of Facility
Joseph H. Brown Jr. Funeral Home PA
2140 N Fulton Ave., Baltimore, MD 21217 21. Signature of Funeral Service Licenses huch 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** Hemorrhagic
Due to (or as a consequence of): stroke disease or condition resulting in death) /Medical **Examiner** Hypertension Sequentially list conditions, if any leading to finine clate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed ng physician and as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as use IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. | the hed 9 Unknown signed by to d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has bodies in the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the autopsy performe 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 은 this After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certification: Division or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: d in by the 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D36663

State

Registrar
DHMH 17 Rev 1/2001

DR STUART

FRANKLIN Square DR Balto Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Willes

9000 F 2. Regist ar's Signature

10-07290
Marian Fletcher

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nanan Fletcher		1- For State Registrar State of Maryland / Department of Health and Mental Hy 1-For State Registrar	_	2010	30795
Physici Medical Exam		1. Decedent's Name (First, Middle,Last)	Date of Deat Month	th Day Year	3. Time of Death
viedicai Exam	iner	Marian A. Fletcher 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	Septembe	4c. County of Deatl	1200 hrs
		Kernan Hospital Baltimore		N/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Bir	th(MM/DD/YYYY) 9. Bir	thplace (State or
Director		212-40-0316 1XM 2F 69 Yrs. Months Days Hours Min.	09/0	6/1941 co	ountry) MD
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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Maryland 282-f show d at once.	Director	10e. Street and Number 10f. Zip Code	10	0g. Citizen of What Cou	ntry?
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hours : natura	ed b	15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Usual Occupation (Give kind of we during most of working life. DO NOT use retire	ork done ed)	16b. Kind of Business/	
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygene. tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examine.	P				
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important. If item 27 is minury or other traumatic.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date Date	20c. Location - City or	
MOF Pages ent of int: If		1 Surial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Arbutus Cemetery		Baltimor	e.MD
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21 Signature of Funeral Service Licensee 22 Name and Address of Facility own 2140 N. Fulton A	Jr.	Funeral H	ome PA
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Examiner		or condition resulting in death) Due to (or as a consequence of):			
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Cardiac fibrosis Due to (or as a consequence of):			
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Division of Vital tal or Attending Physician: rs after death. sal Director: After this certiced in by the fineral director.		. I 27. Manner of Death I 28a. Date of Injury I 28b. Time of Injury I 28c. Injury at Work? I 2	:8d. Describe ho	ow injury occurred	
/iSior r Attenc ter death irector: n by the	ficat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2	28f. Location (St	treet and Number or Rur	al Route Number, City
Divipital of ours af filled i	Certification	4 Homicide determined (Specify)	or Town, Sta	ate)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	edical				
	Σ			29d Date signed (Mon	
	-	30. Name and address of person who completed cause of death (Item 23a)		September 23, 20	,,,,
	- 9	Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201		
St Regist					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

vamer vv. r oliz		1- For State Certificate of Death Registrar Reg. No.	796					
Physicia	an/	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of D						
Viedical Exami	ner	Warner W. Foltz September 18, 2010	rs					
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 102 Hedgewood Drive 4c. County of Death Prince George's						
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace						
v any		10a. State 10b. County 10c. City, Town or Location 10d. Inside 0	City Limits					
Maryland 28a-f show 1 at once.	ţo	MD Prince George's Greenbelt 1 Yes 10e. Street and Number 10g. Street and Number 10g. Citizen of What Country?	2 No					
th the Mar. 23a or 28a notified at	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Hedgewood Drive 207 0 USA						
leath with t r items 23s	Funeral		lack,					
s after c	by F	3 Wildowed 4 Divorced in res, Give rear 76-7/ 1 Yes 2X No specify: Specify: White						
0036 within 72 hours after death with the Maryland siene. rer than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once	Completed							
15-0036 filed within 72 Hygiene. d other than ", the Medical I	Som	12 0 disabled none 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname)						
er ke ata 2	Be	Stanley Warner Foltz Edith Bolton						
MD 21 at 2 should 1 ulth and Mer m 27 is mar aumatic ev	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Lowry/mother 6103 Osborn Road Landover, MD 20785						
		20a. Method of Disposition Surial 2						
Baltimore, permit. Pages 1 an Department of Hee Important: If ite		4 Donation 5 A Other Specify: in state						
Baltimo permit. Page Department Important: injury or oth	Į	21. Signature of Euneral Strice Licensee Ronal S. Wade Director State Anatomy Board 655 W. Baltimore Street	≥t					
Physician /M-di_l		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Between Complete the mode of dying, such as cardiac or respiratory arrest, shock, or heart should be the cause of the disease.						
Examiner	ı	Immediate Cause (Final disease or condition resulting in death) a Combined effects of fentany1 & cocaine Due to (or as a consequence of):	ath					
		Sequentially list conditions, b.						
	Examiner	if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated C.						
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760, iteate be executed g physician and the burial - transit	Medical	☐ AMENDED ☐ AMENDED 3a,27,28a-f,per ME g908 10/8/10 TT						
8760, rificate be ng physici as the buri			Year					
Box 687 ne death certific the attending p	Physician/	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown						
ires that the d signed by the	ρ	1 Yes 2 No 3 Probably 4 🗸						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Completed	24a. Was an autopsy findings prior to completion of concept of the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second seco						
ital Recician: The scertificate rector, page	Bec	25. Was case referred to medical 26. Place of Death (Check only one)						
n of Vil	ျ	1 Ves 2 No 1 Inpatient 2 EN/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Joint 4 Work? 28d Describe how injury occurred						
ion c tending eath. tor: Af	tion	1 Natural 5 Pending Investigation Fd 9.18.10 FD 9:30 am 1 Yes 2 X No unk						
Divisi pital or Att ours after d neral Direct filled in by	ertification:	Accident Investigation 3 Suicide 6 Could not be 4 Homicide Homicide Homicide Accident Investigation Accident Accident Investigation Accident Accide	nber, City					
To the Host within 24 ho To the Func completely f	edical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
D H SH O	ğ							
	Ì	30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
Sta	ate	31. Date filed (Month, Day, Year) 22. Registrar's Signature						
Regist	rar	UCI 0 1 2010 Chana B. Jacks	_ [

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thomas Edward Frazier, Sr. September 28, 2010 4:35 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Min April 5, 1928 82 Hours 217-28-8239 Washington, D.C. Director Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 X No Silver Spring Maryland | Montgomery 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral 20906 12702 Hathaway Drive United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian rmed Forces?
Yes 2 \(\square\) No Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Korea 1 Yes 2 No Specify: White 'natural", Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Heavy Equipment Operator Construction Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hw.
Important: If item 27 is mediany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Viola Frye Not Available 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12702 Hathaway Drive, Silver Spring, Maryland 20906 Helen I. Frazier/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Montgomery 1 ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State September Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 30, 2010 . Signature of Funer Sorvice Licensee Robert A. Fumphrey Funeral Home/Rockville M00198 300 West Montgomery Ave., Rockville, MD 20850-2805 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Days Immediate Cause (Final Physician/ Acute Left Parietal Brain Hemorrhage disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Days Acute Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hypertension Years y physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending philosophers at the IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ileostomy for severe ulcerative colitis(1993) 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate ha irector, page 2 death? 1 🗌 Yes 2 🗆 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🔀 No Other: ပ္ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

/ DHMH 17 Rev 7/2009

State Registrar 29b. Signature and title of certifie

Barbara Ann Supanich

Supanich 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's S

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D65485

1500 Forest Glen Road, Silver Spring, Maryland 20910

28/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Josephine Emily Fones Sept. 24 2010 9:37 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil Co. Union Hospital Elkton If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) OV. 8, 1919 1 □ M 2 😾 F Months Davs Hours Min. Country) Maryland Director 90 213-09-5201 Nov. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Conowingo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21918 United States 129 Leona Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes Give 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years American Can Company Press Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sophie Czyza Joe Nowak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 129 Leona Drive Conowingo, MD 21918 Thomas E. Fones, Jr. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Sacred Ht. of Jesus Cem. 9/28/2010 Dundalk, MD 4 Donation 5 Other (Specify) 21. Signature of Fundal Service Lin Duda-Ruck Funeral Home of Dundalk, Dundalk, MD 7922 Wise Ave. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 1 ☐ Live Birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown in the past 12 months?
1 ☐ Yes 2 🔀 No been signed by the atte should be detached for 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy After this certificate Yes 2 No 1 ☐ Yes 2 🔀 No eral Director: After this certific filled in by the funeral director. 25. Was case referred to medical B 26. Place of Death (Check only one) 1 Yes Other: မ 2 No 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined the Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi

Registrar

State

BKton

21921

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

street

32. Registrar's Signature

BDW

0

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}27, Month Sept. Physician/ 2010 2:00PM M Charlene Shifflett Gillis Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospice Dove House Westminster Birthplace (State or Foreign Country)
 TTA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** May 11, 1945 Min. Hours 1 M 2 F Months VA 65 216-48-3141 **Director** Usual Residence of Deceden 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State must be notified at Completed by Funeral Director 1 Yes 2 No Sykesville MD Carrol1 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Numbe 23a 21784 USA 594 Noland Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates. 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White "natural", 3 Widowed 4 Divorced th and Mental Hygiene.
It is marked other than "natur traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Founder & Operator Mission Store 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Emma Campbell Samuel Edwin Shifflett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 594 Noland Drive Sykesville, MD 21784 Mr. Allen B. Gillis (Spouse) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o County Cremation 10/2/2010 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHPAEL, PA Signature of Funeral Service Kicensee M00764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate Interval Betw shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last physician and the burial-transit Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknow Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 s autopsy death? 2 No 1 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: Dove House 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence ျ 4 Nursing Home 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner-of Death 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation after death

Director: A

d in by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29d. Date sighed (Month. Day. Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) Westminster MD Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Maryland / Dep	artment of Health and M	lental Hygiene	30800				
4	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Last) The Franc's Gazick 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month Day Year September Z6, Z010 4c. County of Death	3. Time of Death				
	Funeral Director		The Johns Hopkins Hospital 5. Social Security Number $157-26-6547$ 6. Sex $1 \square M 2 \square F$ $7. Age (In yrs. last birthday)$ 73 Yrs.	Baltimore City If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day, Year) Co	thplace (State or Foreign untry) nnsylvania				
	ne Maryland 28a-f show tified at	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo TN Knox Knoxvil	le		10d. Inside City Limits 1 ☐ Yes 2🛣 No				
	filed within 72 hours after death with the Maryland Hygione. Wither than "natural", or items 23a or 28a-f show with the Medical Examiner must be notified at	Funeral Dir	10e. Street and Number 7641 Cedar Crest Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	10f. Zip-Code 37938 Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	10g. Citizen of What Co USA ciffy Yes or No- Rican, etc.) 14. Race - Ame Black, Whit	erican Indian,				
21215-0036	72 hours afte 'natural", or i' dical Examine	Completed by Fi	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Dece (Give	1 ☐ Yes 2 ☒ No Specify: dent's Usual Occupation kind of work done during most of worki	Specify: WI	nite				
Ind 2121	be filed within tal Hygiene. d other than 'svent, the Me	To Be Compl	College (1-4 or 5+) 3 Eng 17. Father's Name (First, Middle, Last)		Utility e (First, Middle, Maiden Surname)					
, Maryland	ss 1 and 2 should of Health and Men item 27 is marker other traumatic	욘		Pauling Ong Address (Street and Number or Rura Calon Court, Gaithe	·					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryl. Department of Heath and Martal Hygliens. Important! I flem 27 is marked other than "natural", or items 23a or 28a-f shc any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (Specify) Calvary Signature of Funeral Service Licensee	Cemetery 10/2, 2. Name and Address of Facility Gen	ntry-Griffey Funer	TN cal Chapel				
	Physician	(23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock for heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	o301 Fountain Road er the mode of dying, such as cardiac of		Approximate Interval Between Onset and Death				
	te be executed with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial-transit with the burial	al Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):							
. Box 687	e death certifica he attending ph hed for use as t	Physician/Medical		□ Ectopic pregnancy □ Other (specify)	23d. Date of de Month	livery Day Year				
ecords, P.	w requires that the been signed by th should be detach	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	1 Yes 2 No 3 Pr	cco use contribute to the cause of death? 2 \(\text{No} \) 3 \(\text{Probably} \) Probably 4 \(\text{V} \) Unknown				
<u> </u>	The la	Be Completed	25. Was case referred to medical examiner?	26. Place of Death	autopsy prior to death? 1 □ Yes 2 N No 1 □ Yes	utopsy findings available completion of cause of 2 □ No				
6	Attending Physician: r death. ector: After this certific by the funeral director.	P	27. Manner of Death Natural 5 Pending investigation Plospital: 1 Inpatient 2 ER/Outpatier 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		ne 5 Residence 6 Other (Specaled Describe how injury occurred	city)				
		Il Certification:								
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier	vestigation, in my opinion, death occurr 29c License number RES-DOO	ed at the time, date and place, and du	h, Day, Year)				
,	\(\cap \)	te	30. Name and address of parson who completed cause of death (Item 23a) (Type, 31. Date filed (Month, Day Year) 32. Registrats Signature	Print)	September Z	•				
	Registr	ar	31. Date filed (Month, Day Year) OCT 0 1 2010 32. Registra's Signature							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death O^{Month} Physician/ 1 Bay 20^Y1°0 1740 Hartly Glasgow Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 23 Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F Days Hours New York Director 087-10-6577 90 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland must be notified at Director 1 🎇 Yes 2 □ No Brooklyn Kings ö 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 517 Hancock Street 11233 USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Examiner marked other than "natural", or 1 Never Married 2 Married Completed by Yes f Yes, Give 2 🗌 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: WWII Year or Dates. Black traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Authority Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Controller New York Transit Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Betty Matthew H. Glasgow Angeline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) i. Page 1 and 2 sl tment of Health a tant: If item 27 is jury or other tra 20010 Douglas G. Glasgow/Brother 1746 Lamont St., NW, Washington, DC Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H
Important: If ite
any injury or oth Calverton National 9/23/10 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Calverton, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Austin Royster Funeral Butana Re. -lu M00969 3821 14th Street, NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sersis Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): burial-transi or Attending Physician: The law requires that the death certificate be executed Urinary Tract Infection that initiated events Due to (or as a consequence of resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Prostate Cancer with Metastasis 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Respiratory Failure 24a, Was an this certificate has page 2 performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 XNo မြ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work' s after death. 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Redigial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

completed filled in by within 24 hours a

To the Funeral C Hospital

State

only on

29b. Signature and title of certifier

Sirak Lemma,

31. Date filed (Month, Day, Year)

OCT 0 1 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Registrar

32. Registrar's Signature

29c, License number

1500 Forest Glen Road, Silver Spring, MD

D0065069

09/16/2010

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State Registrar

DHMH 17 Rev 1/2001

within 2 To the

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

Nest Place Sundalle M1) 21222

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Sept. Herbert Richard Grace, Sr. 2010 11:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FutureCare Northpoint Nursing Home Eastpoint Baltimore Co. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 9, 1921 . Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F Months Days Hours Director Maryland 214-16-6403 Usual Residence of Decedent 28a-f shov 10b. County 10a. State event, the Medical Examiner must be notified at by Funeral Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Edgemere 1 Yes 2 X No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a (permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importants if item 27 is marked other than "any injury or other traumatic." United States 6805 North Point Road 21219 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
1f Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced WWII White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Grocer / Store Owner Grocery Store Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Matilda Redtman William S. Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6805 North Point Road Edgemere, Maryland 21219 Mrs. Sudie L. Grace (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/30/201 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park Cem. Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lact only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Carchae Arrhuttymi disease or condition resulting in death) WINS Medical Due to (or as a consequence of) Examiner Continuitarional Decine sureners ve Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of). attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Atrial Film Mation Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate ha 2 🗍 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 1 Natural 2 Accident Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No M Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 ho To the Fune completed fi Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D 39 wi September of 7, 2010

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State Registrar

DHMH 17 Rev 7/2009

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Howers

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tille

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 8:45 a^M Carol Greene W. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday, **Funeral** 1 🗆 M 2 🖵 F Months Days Hours West Virginia 232-50-5872 78 Director Usual Residence of Decedent 10b. County or 28a-f show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d, Inside City Limits Funeral Director MD Baltimore Lutherville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 Dublin Drive 21093 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 XMarried ☐ Yes 2 X☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3
Widowed 4 Divorced Year or Dates. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Claims Examiner Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Cecil Whitten Perdue Gladys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexander McMullen-attorney 1504 E. Joppa Rd., Towson, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Gardens of Faith 10/6/10 Overlea, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Ruck Towson Funeral Home, Inc. Towson, MD 21204 22. Name and Address of Facility Dau 1050 York Rd., 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. e mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition) Medical resulting in death) Examiner Esque Hally list est ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

person who completed cause of death (Item 23a) (Type, Print

29c. License number

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,			For _ State	State of	f Marylar					and M	lental Hy	giene	2010	3	0805
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~	4		Maryland Sanct 5. Social Security Number	uary Holy	7, Age (In yrs.	last hirthday)	Bur		ovi11		8. Date of Bir		Montgome		ata an Familia
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	and show Lat	or	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Insid	de City Limits
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21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed		est grade completed) College (1	-4 or 5+)	(Give I life. Do	kind of work DNOT use r Stodia	done du etired)		of workir	ng	Vi	^{Kind of Business} rginia I hool Sys	Beach	
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Man	2 should th and N 7 is me trauma		19a. Informant's Name/Relations Clinton Clay H		Son	1	_				Route Number		r Town, State, Zip	o Code)	
	f Healt f Healt item 2 other		20a. Method of Disposition		20b. I	Place of Dispo	sition (Name	e of			ate	_	ocation - City or	Town, Sta	te
imo	Page ment c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Otate	cemetery, cren osevelt		er piace		10/4	/10	Ch	esapeake	, VA	
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09/89	ertifica ding p se as t	/We	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, out	come of pregna	ancy							23d. Date of de	li ca m c	
Box	To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial completed filled in by the funeral director, page 2.	Completed by Physician/Medical	in the past 12 months? 1 Yes 2 No 9 Unknown		Birth 2 Feta nant at time of nown		Ectopic pre Other (spe						Month	Day	Year
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Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Certificate:	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At he		M et, factory, o		res 2 🗆				nd Number or Rui	ral Route N	lumber,
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	Hosp 24 ho Fune leted fi	Medical ((Check 2 L Medical E	Physician: To the be examiner: On the bas Nurse Practioner:	is of examinatio	n and/or invest	igation, in my	y opinion	n, death oc	curred at	the time, date a	and place	e, and due to the	cause(s) and	d manner stated.
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	4		30. Name and address of person TEHSEEN	who completed caus	e of death (Iten	n 23a) (Type, P 2835	Sm	ita	A	ve,	Suiti	- 20	29-10 03 Bas	etem	ine MI
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Sheila Hayes		State of Maryland / Department of Health and Mental Hyg 1- For State Registrar Certificate of Death	Reg	2010	30808
Physiciar Medical Examin		CI II- D II-	Date of Death Month September	Day Year 28 2010	3. Time of Death 1818 hrs
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Funeral			8. Date of Birth	(MM/DD/YYYY) 9. Birt	hplace (State or
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21215-0036 Juld be filed within 7 Mental Hygiens marked other than ic event, the Medica	g Re	Nelson Johnson Sylvia L			
D 21 should and Me 7 is man	2	19a. Informant's Name/Relationship (Type, Print), 19b. Mailing Address (Street and Tumber or Rura Heyman Hayes, Jr. / Husband 1508 Poplar Gnove St		er, City or Town, State, Altimpre M	
Te, M 1 and 2 Health Fitem 2	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cernetery, D		20c. Location - City or	
Baltimore, MD Permit Pages 1 and 2 sho Opparatured of Health and Important: If item 27 is injury or other traumati		4 Donation 5 Other Specify: King Memorial Park 10 09		Windsor M	
Balt permit Depart Impor injury		21. Signature of Euneral Service Licenses 22. Name and Address of Facility Value 8728 Liberty Road	Dande	eene Funeva	1 Services
Physician , /Medical	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re failure, Listonly one cause on each line.			Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a Cardiac Tamponade Due to (or as a consequence of):			Death
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Division of Vital Records, P.O. Is a for Attending Physician: The law requires that the safe feath. The form of the first sertificate has been signed by led in by the funeral director, page 2 should be detach.	Completed		autopsy performe		ompletion of cause of
Vital Recysician: The I	a a	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing H			
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	ਰ∣	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the			
5 ± ≥ ± 8	ĕ	29b. Signature and title of certifier 29c. License number		9d. Date signed (Mont	
	-	30. Name and address of person who completed cause of death (Item 23a)		September 29, 20	710
		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	<u></u> .		
Stat Registra	2	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
DHMH 17 Rev 1/200	1	ORIGINAL			

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10e State of Maryland Department of Health and Mental Hygiene 30807 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Diane Wilson Heterington Month 2010 September 7:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Days Hours Director 1048-32-6496 68 08/10/1942 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Montgomery Bethesda 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral Battery Lane, #707 20814 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Organizational Elementary/Seconday (0-12) College (1-4 or 5+) **5 +** 12 Development Life Coach Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည John Heath Wilson Duchka 19a. Informant's Name/Relationship *(Type, Print)* Elizabeth W. Hampton/POW 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4201 Oakridge Lane, Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Final Journey Crem. 1 Burial 2 Cremation 3 Removal from State 10/2/2010 Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Eacility
Maryland Cremation Services
PO Box 1413, Baltimore, MD . Signature of Funeral Service Licenses Dorota Marshall war (ha 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Metastatic Ovarian Cancer Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate コククロ Due to (or as a consequence of): Exami Cause (Disease or iinjury this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Hypercalcemia, Encephalopathy The law requires Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔀 No Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certific To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No ျ 1 Mnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Division of 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) d title of 29c. License number 29d. Date signed (Month, Day, Year) D0060117 9/29/2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric J. Park, M.D. 8600 Old Georgetown Road, Bethesda, MD 20814 31. Date filed (Month, Day, Year)

VDHMH 17 Rev 7/2009

State

Registrar

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ HARRIS Month Day Year Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death HEALTH MID Umort If Under 1 Year Security Number If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Month, Day, **Funeral** 1 M 2 M Months Hours Min 640 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Nes 2 No TIME 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) and Mental Hygiene.
is marked other than "natural", or iterraumatic event, the Medical Examiner! 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced 1ack Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) isab Be Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 item 27 other tra Annie We 4101 timore varman 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) etro 2010 altimore 21. Signature of Foneral Service Censes 140 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death ADVANCUD hysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical to the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Month Day Year 1 Yes 2 Unknown the detached 9 Unknown Division of Vital Records, P.O. כיייי נוהפום: שושכנס: Aner this certificate has been signed by completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 Impatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpa 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No death. Accident
Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) re and title of certifier 29d. Date signed (Month, Day, Year) 10

Registrar
DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

LINDEN

AVE- BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month September 28, 2010 6:26AM Physician Dorothy C. Hejl /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Riverview Nursing Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. May 14, 1913 9, Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) MD 216-07-2163 1 □ M 2 🕅 F Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 □ Yes 2 No Baltimore Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number USA 21221 1 Eastern Blvd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3XXVidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Esskay Packer 12 should be filed w h and Mental Hygien 7 is marked other th 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Unknown Unknown Eversmier ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Max Collins Esq./Guardian 40W. Chesapeake Ave. #200 Towson, MD. permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any injury or other trau 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition . Method of Dispussion.

1 □ Mauriay / 2 □ Cremation 3 □ Ren

4 □ Dopation 5 □ Other (Specify)

Signature / Funeral Sovice Licencee Sacred HeartofJesus 10/01/10 3 Removal from State Baltimore, MD. 22. Name and Address of Facility300 Mace Connelly Funeral Home Ave Balto. MD 21221 of Essex 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) duance d **Physician** Medical Due to (or as a consequence of): xaminer Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed burial-trar Due to (or as a consequence of) Box 68760 attending physician Physician/Medical for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral of ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M-D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D - 21221 (NASEBM 709. EASTERN

DHMH 17 Rev 1/2001

State Registrar Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#25, 28b, e.perME, G909, 10/1/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death I, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 41122 september 2010 Inez Laberta Harris Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner HAY FORD Belair Belgir Health and Rehabilitation Center If Under 1 Year If Under 24 Hrs.

Menths Days Hours Min. 7. Age (In vrs. last birthday 8. Date of Birth
(Month, Day, Year)
Apr. 23. g, Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Country)
Maryland Director 219-18-4266 92 1918 Apr. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Harford Edgewood 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? ò and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be i Funeral 2213 Pine St. Box 155 21040 USA be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 X No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Completed 3 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. George A. Perry Sadie C. Spicer traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2409 Feather Mae Ct., Forest Hill, MD 21050 Steven Harris / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-4-10 Fallston, Maryland Highview Memorial Gdn 21. Signatu of Funeral Pervice Licens ^{22 Name and Address of Facility}
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Subdura disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner \sim 2 weeks Sequentially list conditions, leave to the cause. Enter Underlying Cause (Disease or iinjury Due to or as a consuluence of TOWN REPROVED BY MEDICAL signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Peripheral vascular disease 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? Alzheimer's dementia 24a. Was an autopsy performed?

1 Yes 2 No this certificate has 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After work? 1 🗆 Yes 2 🗙 No 3;40° 5 Pending 🗌 Natural fell out of 09/18 2 Accident 2010 wheelchair Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Nursing Home Room 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1084 410 E. Macphail Rd. Bel Air, ND 2014 Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 006398 2010 MP-30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Benjamin Lee, MP 669 Revolution St Havre de Grace, MD Revolution St. 32. Regişt State Registrar

10-07194 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Sidney Allen Hynson 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3 Time of Death Physician/ **Medical Examiner** 1050 hrs Sidney Allen Hynson September 18, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1700 Block of Warner Street Baltimore 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or unk 5 Social Security Number 1117 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs **Funeral** Foreign Months Days Hours **Director** 1 X M 2 F Country) 61 Oct 15, 1948 Usual Residence of Decedent 10d Inside City Limits 10a. State unk an, 10b. County 10c. City, Town or Location unk unk s 23a or 28a-f show e notified at once. 1 Yes 2 No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code unk unk USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married 2 Yes Yes 2 No specify: white If Yes, Give Year 4 Divorced Specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) lll Penn Street Baltimore, MD O.C.M.E. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other Specify: in state 21. Signature of Funeral Service Licensee ROnald S. W State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 irector 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician een Onset and /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical cate has been signed by the attending physician a page 2 should be detached for use as the burial **AMENDED** UNPENDED Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) funeral director, Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 🗸 Other: Scene 2 ER/Outpatient 3 DOA 2 No 1 V Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 V Natural Pending 1 Yes 2 No Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City Could not be Suicide

To the Hospital or Attending Physician: Division of Vital Director: d in by the f 24 hours after death Funeral Director: filled in by To the

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 19, 2010 nell Mongonie 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date file file file fith, Aay Ye 2. Registrar's Sign

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Homicide 29a. Certifier (Check only one) 2

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State

Registrar

or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 29, 2010 Physician/ 12:26 PM Patricia Collins Hughes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Funeral 1 □ M 2🏖 F Months Days Hours eptember 12. Washington, D.C Director 1924 86 579-22-9629 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director West Virginia 1 Tes 2 No Jefferson Charles Town 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 17115 Charles Town Road 25414 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ⚠ Yes 2 ☐ No 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 X Divorced Completed Year or Dates. Unknown White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Studio 4 Artist/Owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٥ rmit. Page 1 and 2 should be 1 spartment of Health and Menta portant: If item 27 is marked by injury or other traumatic ev Anne Crowley John Paul Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8604 Springdell Place, Chevy Chase, Maryland 20815 Padraic C. Hughes/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I semetery crematory or other place)
St. Peters
Catholic Cemetery 1 X Burial 2 Cremation 3 Removal from State Harpers Ferry West Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy 21. Signature I Jun al Se ce Licensee any MD Chase 4-3501 M00198 7557 Wisconsin Ave., Bethesda, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final ULCER PERFORATED DUODENAL Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Secure felly later willows if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC OBSTRUCTIVE PULMONARY The law requires 2 No 3 ☐ Probably 4 ☐ Unknown Records, 1 🗀 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ALSEASE 24a. Was an autopsy performed Yes 2 Hughes To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificat. of Vital filled in by the funeral director, B B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 🗌 Yes Certificate: To Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗀 only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) suo, MD DOO 5 7124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Drive #206, Rockville, Maryland Truong Bao, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Michael Hargest September 29, 2010 Year 7:22 AMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Baltimore Timonium Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral Months Days Hours Min. 1 X M 2 - F Yrs. Mary I and Director 215-24-9004 81 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A ms 23a or 28a-f s must be notified Baltimore Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3404 Roselawn Avenue 21214 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1947— If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by 1 Yes 2XNo Specify: 1950 Specify: 3 Widowed 4 Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Representative Industrial Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Henry Hargest Julia Cecelia Griffin 19a. Informant's Name/Relationship (Type, Print) ib. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3404 Roselawn Avenue Baltimore Maryland 21214 permit. Page 1 and 2 sh
Department of Health an
Important; If item 27 is
any injury or other trau Sophie Hargest/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Mem. Park 10/2/10 Baltimore Maryland Signature of Funeral Service Licenses 1 Mannaged Addressative inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition LUNG CANCER Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or ilinjury that initiated events Due to (or as a consequence of): resulting in death) Last Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ To the Hospital or Attending Physician: The law requires that the death owithin 24 hours after death.

To the Funeral Director. After this certificate has been signed by the atten completed filled in by the funeral director, page 2 should be detached for upon probled filled in by the funeral director, page 2 should be detached for upon the funeral director, page 2 should be detached for upon the funeral director, page 2 should be detached for upon the funeral director. in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No 2 **X** No 1 Yes Yes 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner?
1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Contriguing Nurse Fractionar: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title 29c. License number ess of person who completed cause of death (Item 23a) (Type, Print) JACKIÉ JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State

Registrar

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Imbraguglio Agata (nmn) Medical 16 Facility Name (if not institution, give street and numb Examiner If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days , *Day*, Ye 1 □ M 2 🕱 F Months Hours Min Yrs Director 216-28-9045 84 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f st notified a 1 Yes 2 X No Maryland Harford Bel Air 10e, Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Completed by Funeral 2110 Windom Ct. 21015 USA permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Giovanni (nmn) Carbone Giuseppa (nmn) (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Manzo / Daughter 2110 Windom Ct., Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Catheral Cemetery Baltimore, Maryland 10-2-10 Name and Address of Facility McComas Funeral Home, 1317 Cokesbury Road, Funeral Service Licenses Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each the Do not enter the mode of mg, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) weel Medical Due to (or as a consequence of) Examiner Sequentially list conditions. If any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exam eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 25. Was care referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner_of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending Division 1 Yes death Investigation Could not be Accident hin 24 hours after deat the Funeral Director: 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Natse Pragmoner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a and address person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State OCT 0 1 2010

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last 2. Date of Death Physician/ 1:00 A Medical 4a. Facility Name (if no institution, give street and number) Examiner Town, or Location of Death 4c. County of Death 8. Date of Birth Birthplace (State on Foreign Country) **Funeral** 1 M 2 X F (Month, Pay Director or 28a-f show 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director er than "natural", or items 23a or 28a-fs the Medical Examiner must be notified 1 X Yes 2 ☐ No more 10g, Citizen of What Countr Funeral rossW000 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🔀 No ð Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Completed ac Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within тепт of Health and Mental Hygiene. College (1-4 or 5+) ulth and Mental Hygiene. 27 is marked other than r traumatic event, the N Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden ဂ္ ames Iden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Jacksoni lonica 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) -2010 Owings 21. Signature of Funeral Service Licensee areene. more 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ta Physician/ disease or condition resulting in death) 16 Medical Due to (or as a consequence of Examiner hij thm. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed insetes nellitu and as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician DiSTASZ Physician/Medical ascula P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Year detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be Records, 1 Yes 2 No 3 Probably 4 Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' 2 No this certificate Yes 2 1 🗌 Yes Division of Vital within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director director director director. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🔲 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P0054318 3012010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 (211 Mo MA 3623 Falls Baltimore Rund

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Vany 31. Date filed (Month, Day, Year,

32. Registra is Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death C Month Day Year Physician/ septembe 2010 . Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner NIA zitimore swynnaale If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | Month, Day Year Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 D F Months 218-60-424 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland notified at Director 1 Xes 2 No 28a-f timale 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number must be r Funeral 2120 winnall items ? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or iten edical Examiner r Armed Forces' Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Blac If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) the Medical Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
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Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic
once. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore Be Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ ones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 HHOLO MOVAVIA APT 8, Baltimae, MD 19a. Informant's Name/Relationship (Type, Print) Apt 8 Jackson 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Baltimore 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Heights Ave Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ 5uddeN CARDIAC DEAR disease or condition resulting in death) Medical) Medical Examiner Due to (or as a consequence of) CARDIOMYORATH Years NON ISCHENNIC Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence on burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 4 Pregnant : 9 Unknown signed by the air d be detached for 1 Yes 2 g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed 1 Yes 2 No 2 No this certificate Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1835 Greene Tree Rd DuBo is

DHMH 17 Rev 7/2009

State

Registrar

21208

land

VICTOR

gistrar's Signature

BENJAMIN

OCT 0 1 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Juratorac 0455A M Christine 23 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CALVERT MEMORIAL HOSPITAL PRINCE FREDERICK CALVERT 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year)

JULY 4, 1934 MARYLAND If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 💢 F 76 214-38-0913 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 28a-f show injury or other traumatic event, the Medical Examinar must be notified at 1 ∐Yes 2 🛛 No Director BALTIMORE **ESSEX** MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or 21221 U.S.A. 1000 FRANKLIN AVENUE #205 Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ∐Yes 2/QNNo Specify: þ WHITE 3 ▼Widowed 4 □ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 than College (1-4or 5+) GOETZE CANDY CO. LABORER permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important; If item 27 is marked other i any injury or other traumatic event, ID 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MICHAEL THEODORE BACCALA ALBERTA ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19453 PRARIEVIEW TERRACE, OREGON CITY, OR THOMAS JURATOVAC/ SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State BAYVIEW CREMATORY 9/24/10 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Europe Service Licensee 22. Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME
1901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** premine Asperatea /Medical Due to (as a consequence of): Examiner 40 Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed and burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 □Yes 2 XNo Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 🗌 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0061783 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ince Redencil, MO ZOL Hospital chana 101 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 1. parl

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010 Month Physician/ A M Sep. 4:38 Jane Kaiser Patricia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rising Sun Calvert Manor Health Care Center Cecil Birthplace (State or Foreign Country)
 Ohio 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Nov. 10, Days Hours Min. 1 🗆 M 2 🔀 F Ohio Director 84 278-20-8701 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits death with the Maryland Director 1 🗌 Yes 2 🕱 No Lambertville MI Monroe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3467 Section Road 48144 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc 1 Never Married 2 Married þ filed within 72 hours after Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: If Yes, Give Specify 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Interior Designer Construction 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Sophia Winkle Joseph Hensler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3467 Section Road, Lambertville, Michigan 48144 Paul Kaiser - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Our Lady of Mt.
Carmel Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) 9-24-2010 Temperance, MI Michael W. Pawlak Funeral Home 22. Name and Address of Facility 21. Signal re of Fur eral Service Lice 1640 Smith Road, Temperance, MI 48182 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Jementia 0 2415 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause (Disease or iinjury Usin to (or as a nonsequence of) led by the attending physician and detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year 1 ☐ Yes ∠ ≥ 9 ☐ Unknown Unknown Part II. **Other significant conditions** contributing to death but not res<mark>u</mark>lting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be de þ Chronic Obstructive 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of WEBTESSION 24a. Was an autopsy perforn death? Yes 2 No 1 Yes 2 No this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ANo Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work?
1 Yes 2 No Natural Accident 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 00058354

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LATTIN, M.D. 101 COLONIA

32. Registrar's Signature

٤.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 30 Physician/ 2010 Helen Kramer 11:46 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimre Baltimore Loch Raven Genisis Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔯 F Months Hours Min. Nov. Pay, Year 22 MD 87 Director 214-14-7455 Usual Residence of Decedent 28a-f show iral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland Director Pasadena. Maryland 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 21122 7639 Laurel Drive 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Line Worker Manufacturing Assembly Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည McCuin pe permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic & once. Clarence Corun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21122 7639 Laurel Drive, Pasadena, Michael J. Kramer 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Oct. Date 01 cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Metro Crematory Inc. 4 Donation 5 Other (Specific 2010 21. Signati 22. Name and Address of Facility e of Stallings Funeral Home, PA 3111 Mountain Road, Pasadena, s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part 1. Enter the dise se, or complication Approximate interval Between ist only one cause shock, or heart failure. Onset and Death Immediate Cause (Final -Pnysician/ disease or condition Medical resulting in death) Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and -transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician as the burial-Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has page 2 s autopsy death? Yes 2 No 1 Yes 2 No this certificate 25. Was case referred to medical examiner? Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 KX Nursing Home 5 - Residence 6 - Other (Specify) 2 📉 No ျာ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 🗌 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year 20

Registrar

DHMH 17 Rev 7/2009

State

Registrar UCI UI 201

31. Date filed (Month, Day,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type,

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1,20 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Montgomer If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 № M 2 🗆 F Months Days 219-04-5263 Hours Min. March 2 **Director** Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director 1 Ses 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a Funeral any injury or other traumatic event, the Medical Examiner must Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White etc. <u>გ</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🛂 No 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory 1 Burial 2 Cremation 3 Removal from State of ☐ Other (Specify) uneral Service Licer toxu 20799 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Priysician Carcinoma cancer disease or condition resulting in death) Liver YEARS Medical Due to (or as a consequence of): Examiner YEUL-S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death sate has been signed by the a page 2 should be detached to g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 ♥No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital 2 No 1 Tes 잍 1 Inpatient 2 ER/Outpatient 3 IDOA 5 M Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🔲 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier I Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2010 physician Dee Cu

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DHMH 17 Rev 7/2009

Registrar

21228

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ september 25, 2010 Gloria Kneeland 11:55 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Baltimore **Examiner** Baltimore Riverview Nursing Center If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Hours JUTY 3", 1939 71 046-30-1138 **Director** onnecticut Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item on other trainment. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 179 Marine Oaks Drive 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White 3 - Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Donald McKay Jeannette Doyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colin Cresser/ Son 179 Marine Oaks Drive Baltimore, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Bayview Crematory | 09/28/10 1 Burial 2X Cremation 3 Removal from State Baltimore, MD. Modation 5 Other (Specify) 22. Name and Address of Facility 300 Mace Avenue Balto MD Connelly Funeral Home of Essex 21221 of Funeral Service Licen Le . Sign 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final EMENTIA Ph sician/ disease or condition resulting in death) , Medical Due to (or as a consequence of) Examine Sequentially list conditions, Examine tay, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for ea a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 1 Yes 2 9 Unknown 4 ☐ Pregnant : 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown certificate has been irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work?
1 \(\sum \) Yes 2 \(\sum \) No 5 Pending Accident Investigation Accider
Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, Homici determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature an 29d. Date signed (Month, Day, Year) 00060560

Registrar

DHMH 17 Rev 7/2009

State

PAILADELPHIA RD

leted cause of death (Item 23a) (Type, Print)

32. Registra 's Signat

9106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER 2010 JEAN GLORIA KOCHOWICZ 10:10 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BRIGHTVIEW ASSISTED LIVING BEL AIR HARFORD 8. Date of Birth
(Month, Day, Year)
Dec. 28, 1929 If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🔀 F Hours Pennsylvania 167-24-2506 80 Director Usual Residence of Decedent show e filed within 72 hours after death with the Maryland tal Hygiene. other than "natural", or items 23a or 28a-f shooe other than "natural", or items be notified at event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Forest Hill Maryland Harford 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21050 931 Delray Drive USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11 Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+ Vice President Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic ever .. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked or ပ Pearl Viola Bastian Dewey (nmn) Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daryl J. Salamone / Son 1408 Lytham Ct., Bel Air, MD 21015 Department of Health Important: If item 2; any injury or other tonce. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1

Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cem. 12-3-10 <u>Arlington, Virginia</u> ²² Name and Address of Facility McComas Funeral Home, 1317 Cokesbury Rd., A Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pola Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Sequentially list conditions Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ ģ in the past 12 months? Month Year been signed by the s 1 ☐ Yes ∠ □ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s certificate has autonsy 1 Yes 2 No Yes 25. Was case referred to medical Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ this 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate; 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. ☐ Accident Investigation the 1 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 29b. Signature and title of certifie 29d. Date signed (Month, Dav. Year. 29c, License number D3552 Sept. 25, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David S. Dunn 615 W. MacPhail Road, Bel Air, MD 21014

DHMH 17 Rev 7/2009

State Registrar 32, Regist

r's Sign ture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Woo Month Kim 2105 PM september Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Adventist montgomer Grove Hospita Rockville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 D F Days Hours Min. Director Usual Residence of Decedent 28a-f show 10a. State injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 ☐ No WOOC nortaomeri 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 9 þ 1 Yes 2 If Yes, Give Year or Dates 2 100 1 ☐ Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Sia 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) wner 12 To Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or come. pe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kumdaughter 20855 erwood Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of netery, crematory or other place 1 🗌 Burial Cremation 3 - Removal from State M 5 Other (Specify) 4 Donation e of M neral Service Lic Most Funeral 23a. Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ anoxie bra disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) GERTECATION APPROVED BY MEDICAL EXAMINER Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year Dav Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Depression 1 Yes 2 No 3 Probably 4 Unknown has been signed by 2 should by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate ha irector, page 2 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be B 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Hospital 2 | No Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident iniury 5 Pending work? 1 ☐ Yes 2 XNo atient hung himself from Ceiling 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7115 Mill Run Dr Derwood, MD 09/15/2010 Investigation unknown 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined home 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signa 69336 September 17,2010 and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, MD MI 9901 Ctr Dr. Sanelle Williams medical State Registrar

2012

2010

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** hel 310 PM 26 09 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Calvert Calvert Memorial Hospital Prince Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🔽 F 87 Director 459-30-5587 Apr 21, 1923 Texas Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b County ir than "natural", or items 23a or 28a-f show 10d. Inside City Limits Director MD Calvert 1 ☐ Yes 2√☐ No Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12901 Pine Lane 20657 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2**X** No þ Specify. Specify: white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, I.M. M. once. College (1-4or 5+) secretary federal government 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) William Owen Boarman Inez Cobb ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Littleford/friend 341 Pilot Way Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🖾 Donation 5 ☐ Other (Specify) permit. 21. Signatur Funeral Service Licensee 22. Name and Address of Facility Virector Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) **Physician** reakon neur days /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death for 1 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day Month Year 5 Other (specify) the ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4★ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate performed' Division of Vital 1 □ Yes 2 **2** No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2√No 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061783

State Registrar Name and address of person who completed cause of death (tem 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #9,12,15,16a&b&19a&b Per ANA BD G911 1/28/2011 JH State of Maryland / Department of Health and Mental Hygiene for State Registrar 30825 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MOS KEARING 930 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CROSS HOSPITAI N. Sthp 200 Kate or Foreign Country) SV PR JE11 If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 7. Age (In yrs. last birthday) **Funeral** 1 M 2 D F Months Days Director Yrs 068-16-2627 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD MONTGOMERY KENSINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3000 20895 USB 2 AMO. AVR items 2 12. Was Decedent Ever in U.S. Armed Forces?

1. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates. Specify: WHILE "natural", 3 ₩Widowed 4 □ Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation oe filed wm. ⊶al Hygiene. ∽ar **than** "r 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HEALTHCARE - PSYCHIATRIST 12 4 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental H မ permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic t NNK UNK 19a Informaci's Name/Relationship (Type Print) Mary Susan O'Connor/daughter 1967 520 no Setter Strait Production or Rural New Nicean Stan Tow C Ptate, 06840 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ★ Other (Specify) in state Ronald S. Wage State Anatomy Board 655 W. Baltimore Street 21201 1timore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEVERE DEHYDRATION disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and I-transit FAILURE TO resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 1 Yes 2 9 Unknown ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No page death? 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No 1 Yes ER/Outpatient 3 DOA |요 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify, this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicido 24 hours after death. Funeral Director: A 1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ne D60826 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLEN RD HAMA 6 MD FOREST 1500 31. Date filed (Month, Day, Year) 82. Registrar's Signature State OCT 0 1 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30826 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Teng-Au Kuo Medical September 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ho1y Cross Silver Spring Hospital Montgomery Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth Date of bill. (Month, Day, Year Dor 25 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Hours Min 212**-**94**-**3265 Director 103 China December 1906 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 10d. Inside City Limits 1 Tes 2 No Maryland Montgomery <u>Silver Spring</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13317 01d Forge Road United States 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or Completed by 1 Never Married 2 Married Black, White, etc. 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify: Asian Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Senator Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Fu Kwan Kuo Leng Kuo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tzee-Nan Lo/Daughter 13324 Old Forge Road, Silver Spring, Maryland 20904 Date 2 October 2, 2010 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ⊠ Burial 2 □ Cremation 3 □ Removal from State
 □ Donation 5 □ Other (Specify) cemetery, crematory or other place)
Parklawn
Memorial Park permit. Page Department of Important: If any injury or Park Rockville, Maryland Signatur of Funeral Service License Robert A. Pumphrey Funeral Home, Rockville, 300 W. Montgomery Ave., Rockville, MD 20850 Inc. auar) M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Concestive Heart Failure Medical Examiner Acute Myocardial Infarction Sequentially list conditions Examine duy, leading to immediate cause. Enter Underlying Cause (Disease or injury signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed Dementia that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 onths?
1 Yes 2 Vo 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death Unknown Day Month Year 1 ☐ Yes ∠ 9 ☐ Unknown ♣ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 \square Yes 2 X No 3 \square Probably 4 \square Unknown peen has Be

Division of Vital Records, P.O. Box 68760 this certificate To the Hospital or Attending Physician: in 24 hours are, and the Funeral Director: After a lated filled in by the fur

25. Was case referred to medical examiner? 1 Yes 2 X No	1 X Inpatient 2 ER/Outpatient 3		lome 5 ☐ Residence 6 ☐ Other (Specify)				
1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year) injury M	work? 1 Yes 2 No	28d. Describe how injury occurred				
4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
(Check 2 Li Medical Examin	ler : On the basis of examination and/or investigatio	n in my opinion death occurred	at the time date and place and due to the power(s) and process to the				
29b. Signature and title of certifier	9 cass	29c. License number	29d. Date signed (Month, Day, Year)				
20. Name and address of payeer who as		D60826	September 23, 2010				
		C	W 1 1 00010				
31. Date filed (Month, Day, Year) OCT 0 1 2010	32. Registrar's Signature	, Sliver Sprin	g, Maryland 20910				
	examiner? 1 Yes 2 X No 27. Manner of Death 1 X Natural 5 Pending	examiner? 1	examiner? 1				

DHMH 17 Rev 7/2009

State

Registrar

completed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 29^{ay} 2010^{ar} Sept. 1:00 Suzanne Krach Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Langtry Glen Arm Baltimore 8. Date of Birth Sept 12 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Hours Min. 215-32-4671 78 Mary land **Director** Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Glen Arm 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4425 Langtry 21057 U.S.A. Drive Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced er than "natur , the Medical ! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home maker 7 is marked other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Carl Glenroy Francis Emma Elizabeth Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Eugene Philip Krach, Jr. / Son 1112 Moores Mill Road Bel Air, Maryland 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

Dulaney Valley Mem. Cdns. 1 X Burial 2 Cremation 3 Removal from State 10/2/2010 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Santa Lio 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final larcher ascurar disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Year signed by the a 9 🗌 Unknown Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 mulation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate ha irector, page ? myel and performed? Yes 2 25. Was case referred to p 26. Place of Death (Check only one) Hospital 2 No Other 1 Yes မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation
6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar

MDHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as sta

670/ N Charles Mirel Gallinore Md 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CRRILI TOIC EPTEMBOR Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death County of Death **Examiner** WHER BALTIMOR ILCHRIST 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🗶 Months . Hours Min June 12, Year 944 Maryland 216-42-6668 66 **Director** Usual Residence of Decedent show 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland ms 23a or 28a-f shormust be notified at Director Baltimore MD Baltimore 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 503 Riverside Drive 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. à 1 Never Married 2X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event; the Mee once. other than Elementary/Seconday (0-12) College (1-4 or 5+) 11 Custodian Baltimore County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John F. Pfeifer Gladys Meyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rodney Locklear/Husband 503 Riverside Drive Baltimore, MD. 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Oak Lawn Cemetery 10/02/10 Baltimore, MD. 21. Sign: ure of Funeral Service, Licensee 22. Name and Address of Facility 300 Mace Connelly Funeral Home Avenue Balto MD of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ UNGCANCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list non ditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregrant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown for Month Day Veal 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CORCNARY ARTERY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of sause of 24a. Was an nas autopsy page death? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 🗖 No Other: မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: Ai
completed filled in by the fu Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🖆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 7 Physician/ Landes olanda Zay 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 3508 Back Pointe Ct. <u>Abingdon</u> If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | 1925 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Honduras Director 213-76-6659 85 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🎽 No Harford Abinadon Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral nit. Page 1 and 2 should be filed within 72 hours after death with authent of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natural", or items 23a injuy or other traumatic event, the Medical Examiner must b 3508 Back Pointe Ct. 2B21009 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ≥ 1 Never Married 2 Married ☐ Yes 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify. 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 landa andes 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mercedes Guevara Pinel Augustin Franco Guevara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trak 3004 Bellechasse Rd., Fallston, MD 21047 <u>Jean L. Lvnch / Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🗆 Burial 2 🗵 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 10-2-10 Towson, Maryland n ure of Funeral Service Sicensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, 23a. Part 1. Erner the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) burial-transi Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year To the Hospital or Attending Physician: The law requires that the dec within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes 1 Yes 2 No 3 Probably 4 Unknown Completed Hypertension 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify, 2 No 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending 1 🗆 Yes 2 🗆 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 🛄 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29d. Date signed (Month, Day, Year) 9/24/2010 0023519 30. Name and address of gerson who completed cause of death (Item 23a) (Type, Print) Belace Pd

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State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No ... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 27, Physician/ Leora M. Lawlah 2010 5:30 PM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 1 □ M 2 🗓 F (Month, Day, Year Director 100 578-34-2124 Illinois May Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Prince George's 1 Yes 2 No Temple Hills 10f. Zip Code 10g. Citizen of What Country? Funeral 3803 24th Avenue 20748 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give ≥ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 □ Divorced Specify: black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) educator education 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Ralph McCarrell Frankie Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3801 24th Avenue Temple Hills, MD 20748 19a. Informant's Name/Relationship (Type, Print) John Wesley Lawlah III/son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wad 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part 1. A ter the diseas , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o eart failure. List only one cause on each line.

Immediate Caus. Fi Approximate Interval Between Onset and Death Physician/ ACUTE Atherosciente Cardio Vascular diseme disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner THRERTENCION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) signed by the atte Month Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 24 hours after death. Records, DISURDED 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 1 Yes 2 No Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 24 hours a Funeral I Medical 🔑 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

Registrar

State

Suil E

OCT 0 1 2010

31. Date filed (Month, Day, Year)

Hospital CANE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANILK MAYATAMAN D.

150689

7503 Survities Rean

State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 29, 2010 ear **Physician** 12:59 рм Francis Mace Love, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Stanmore Road Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth NOV 1, 1953 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 09/29/10 1259PM **Funeral** Days Hours Min. MaryTand Months 1 ☑ M 2 □ F 56 217-48-0976 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination in the notified at 1 ☐ Yes 2 X No Baltimore Funeral Director MD **Baltimore** 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21212 U.S.A. 173 Stanmore Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐Yes 2 🕅 If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 💢 No Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: White Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Grocer Grocery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Love, Sr. Jeanne Francis Mace ဂ -rancis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 173 Stanmore Rd., Baltimore, MD Jimmy Love-brother Department of Health Important: If item 27 any injury or other trong once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/4/10 Woodlawn, MD Woodlawn 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Landlo vasculor -tendeclenatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown cate has been si page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The certificate 1 □Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and HillCTInthan: 1/p, Md 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Susan Mae Marangi September 30. 2010. 10:02 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2**X** F Months Davs Hours Min. (Month, Day, Year) 535-48-6889 62 Director Seattle May 16. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No Maryland Baltimore Parkville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21234 United States 3034 Woodside Drive 11. Marital Status 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 2 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Industrial Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Max Amedieo Marangi Maisie Isabelle Cree 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earleen Lozen (Friend) Federalsburg, Maryland 21632 123 Bloomingdal Avenue Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Fvans Funeral Chapel—Bel 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 Burial 2 X Cremation 3 Removal from State 10-02-2010 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 22. Name and Address of Facility
Livens Funeral Chapel & Cremetion Services Parkville
8800 Harford Road Parkville, Maryland 21234 Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause Vinal disease or condition complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 youths? Day Year 5 Other (specify) Month Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Hospita Other: 1 Yes 2 No 잍 4 Nursing Home 5 Residence 6 the Kenter (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? s after death.
I Director: Affer in by the fu 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Mo

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egistrar's Signature

30/Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State of Maryla	•	artment of Heat tificate of Dea			Reg. No.2 1	0 30833		
	Physicia	n/	Decedent's Name (First, Middle, Last)					2. Date of Dea	th Day Yes	3. Time of Death		
	Medic	al	Walter 4a. Facility Name (if not institution, give s		Medlin	4b. City, Town, or Lo	cation of Death	Septem	4c. County of D	10 11:12 AM		
فرر	Examin	er	Sinai Hospital of			Baltima		ty_	40. Obulity of B			
ļ	Funeral Director		1/8-26-946/	7. Age (<i>ln yr</i> s	s. last birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 27	Year) 9.	Birthplace (State or Foreign Country) PA		
	and show lat	or	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits		
	Maryl 28a-f otifiec	irect		imore		Reisterst	own			1 ☐ Yes 2 ☒ No		
	ith the 23a or st be n	ral D	10e. Street and Number	m+		10f. Zip Code	136		10g. Citizen of What	Country? U.S.A.		
	eath w tems? er mus	Funeral Director	5 Angus Cou	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hispa f Yes, specify Cuban, M		cify Yes or No-	14. Race - A	merican Indian,		
9500-61212	e filed within 72 hours after death with the Maryland tal Hygiene. I dether than "natural", or items 23a or 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 🖾 Married 3 ☐ Widowed 4 ☐ Divorced	1 1 Yes 2 No If Yes, Give Kore Year or Dates.		1 Tes, specify Cuban, in		nican, etc.)	Black, W Specify:	White		
2	72 hou "natu edical	Completed	15. Decedent's Edi (Specify only highest grad		(Give	dent's Usual Occupation		ng	16b. Kind of Busine	ss Industry		
717	within giene. er thar the M		Elementary/Seconday (0-12)	College (1-4 or 5+)	lite. D	O NOT use retired) Salesperso	on		Sa	les		
◙	should be filed vand Mental Hyg 7 is marked othe raumatic event,	To Be	17. Father's Name (First, Middle, Last)			18			Maiden Surname)			
Maryland	should be file and Mental I is marked c	-	Walter 3	oseph Medl:		ng Address (Street and		Stella Poute Number	Vinsavage			
Σ	d 2 sho alth an 1 27 is or trau		Joan Medlin Wif	-		ngus Court		rstown,	-			
saltimore,	e 1 and c of He if item or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 I		o. Place of Dispo cemetery, crer	osition (Name of matory or other place)		Date	20c. Location - City	or Town, State		
<u>=</u>	it. Pag intment intant: injury o		4 Donation 5 Other (Specify) 21. Signatury of Buneral Service License	(Cremation		29/10	Hampstea			
g	permit. Page 1 and 2 should be fi Department of Heath and Mental Important: If item 27 is marked any injury or other traumatic ev once.		21. Signature of Princeral Service License	m - Jen	Kens E	2. Name and Address of LINE FUNER	AL HOME	24 Reist Reister	terstown H rstown, MI	Road) 21136		
ı			23a. Part 1. Enter the disease, or compl shock, or heart fallure. List only on	ications that caused the de e cause on each line.						Approximate Interval Between		
- 1	nysician Medical	7 1	Immediate Cause (Final disease or condition resulting in death)	Sepsis						Onset and Death		
	Examiner		resulting in deathy	Due to (or as a cons		intection	n			5 days		
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	equence of):					5 days 2 months 8 years		
	ecuted and -transi	xan	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a cons		fistula	 			2 montos		
09/	cate be executed physician and s the burial-transil	edical Examiner	L.	<u>Prostate</u>	e can	ev				8 years		
280	ertifica ding pl		IF FEMALE:	3c. If yes, outcome of preg	gnancy				23d, Date of	delivery		
. Box	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 F 4 Pregnant at time 9 Unknown		Sctopic pregnancy Other (specify)			Month	Day Year		
л Э	s that t gned b	by P	Part II. Other significant conditions con							e to the cause of death?		
rds,	equire	eted	Congestive heart	factore, C	nvouc	Maney as	sease	24a. Was a		Probably 4 Unknown		
Division of Vital Records,	The law r cate has b page 2 sl	Completed						autop perfor 1 Yes	osy prior rmed? deat 2.24No 1	eautopsy findings available to completion of cause of h? Yes 2200		
Ita	sician: certifii	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	☐ EP/Outpatio	Othor	of Death (Check		lence 6 🗆 Other (S	naciful		
10 U	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s	cate: To	27. Manner of Death 1 ★ Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of	f 28c. Injury at work?			ow injury occurred	pecny)		
INISIO	l or Atter after dea Directors d in by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Abuilding, etc. (Spe		eet, factory, office		28f. Location (S City or Tow	(Street and Number or Rural Route Number, own, State)			
_	Hospita 24 hours Funeral eted filled	Medical	(Check 2 Medical Examin	cian: To the best of my kn er: On the basis of examina e Practioner: To the best of	ation and/or inves	stigation, in my opinion,	death occurred at	the time, date a	nd place, and due to t	the cause(s) and manner stated.		
	To the within To the Comple	Σ	only one) 3 \(\subseteq\) Certifying Nurse 29b. Signature and title of certifier	Practioner. To the best of	A O	29c. License nu	umber		29d. Date signed (M			
			I was de	me	MU		8014		91281	2010		
			30. Name and address of person who co			i Hospital	of B	altim	ove			
ï	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sig								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Sept. 2010 Mathieu 4b. City, Town, or Location of Death 4c. County of Death Linthicum Heights 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 ☑ M 2 ☐ F Months Hours

For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Raymond 01:25 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Tate Hospice House Anne Arundel 5. Social Security Number 9. Birthplace (State or Foreign Funeral (Month, Day, Yeb. 20 218-12-3299 MD 88 **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 28a-f Maryland Anne Arundel 1 Yes 2 No Pasadena 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral 212 10th Street permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other any injury or other to 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11 Marital Status 14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ğ 1 Never Married 2 Married X Yes 2 🗌 No White 1 ☐ Yes 2 No Specify: If Yes, Give 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Chemical Engineer Drug_Company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ R. Mathieu Edna Μ. Klein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret MacDonald (niece) 212 10th Street, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brooklynn, Maryland 2010 Stallings Funeral Home, P.A. 21. Signature of Puneral Service Licensee 22. Name and Address of Facility 3111 Mountain Road, Pasanena, MS 23a. Par. 1. Enter the visease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail yes. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Impury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate Be Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury 28c. Injury at Certificate: After t Natural Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Director; / Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Norse Practioner: To the best of my knowledge eath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature

State Registrar

DHMH 17 Rev 7/2009

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 230 PM MCC Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death County of Death BALTIMORE **Examiner** RANDALLSTOWN KANDALLST Own 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months (Month, Day Director Yrs Usual Residence of Decedent or 28a-f show 10a. State 10b. Count 10c. City, Jown or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 1 √es 2 □ No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral other than "natural", or items 23a 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 2 No Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed, 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, should be filed and Mental H မ permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, Zip Code) Wendell 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) . Signatur of Funeral Service Licensee 22. Name and Address of Facility any Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. cardiac or respiratory arrest Approximate Interval Between Ons t and Death Immediate Cause (Final PNEUMONIA Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** SPHAGIA Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 b 9 ☐ Unknown signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTA 2 No 1 - Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natura 5 Pending Accident Investigation ✓ Accider
 ✓ Suicide within 24 hours after deatl To the Funeral Director. 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town. State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TY ROAD; 9109 TEFOR State Registrar

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10-07077	
Marian Mokotar	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/larjan Mokotar	1.	- For State	State	of Maryla		rtment of tificate of		d Mental H			2010	30835
Physician		egistrar I. Decedent's Name (Firs	st, Middle,La	nst)					2. Date of De			3. Time of Death
Medical Examine		Marjan M							Month Septemb	er 14, 2	Year 010	1013 hrs
	4	a. Facility Name (if not in 6940 Brookmill			nber)		4b. City, Town, or Pikesville	Location of Deat	h		County of Deat altimore Co	
Funeral Director	5	5. Social Security Number		Sex The second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second o	7. Age (In yrs. Ia	ast birthday) 57 _{Yrs}	If Under 1 Year Months Day		_		Forei	rthplace (State orunk gn buntry)
,	-	Isual Residence of Dec			Lio. or							10d. Inside City Limits
w any	1	10a. State 10b.	County Balti	more	10c. City,	Town or Locat Pikesy						1 Yes 2 No
the Maryland a or 28a-f show		10e. Street and Number		-	0.D		10f. Zip Code	015		10g. Citize	en of What Cou	
the N		0940 BTC	_unk		edent Éver in U.		s Decedent of His			10- 1		rican Indian, Black,
Rer death with ", or items 23 er must be no		1 Never Married 3 Widowed 4		1 Yes ed If Yes, Give Year	2 No U	nk	es, specify Cubar		o Rican, etc.)	s	White, etc.	white
2 hours at "natural Examin	ered by	15. Decedent's Education		or Dates: only highest grad College (1-		16a. Deceder during m	nt's Usual Occupa lost of working life	tion (Give kind of b. DO NOT use re	work doneun tired)	k 16b. Kii	nd of Business	Industry unk
Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	╸∟	unk 17. Father's Name (First	. Middle. La	unk			unk	18.Mother's Nam	ne (First, Middle	, Maiden S	umame)	unk
1215. d be filed ental Hy arked of event, th						10h Mailin	g Address (Stre	ot and Number or	Pural Poute N	imber City	or Town State	
D 21 should and Me 7 is ma natic ev	2	19a. Informant's Name/R $0.C.M.E.$	(elationsnip	(Type, Print)		1	Penn St				21201	c, 21p code)
e, M l and 2 Health item 2	1	20a. Method of Dispositi					ition (Name of ce		Date	_	ocation - City o	r Town, State
MOF Pages ent of nnt: If		1 Burial 2 C			om State	o, o, inaco, y o. o.	no. place,					
Salti ermit. epartm nports	Ī	21. Signature of Funeral	Service Lic	ensys///	irector		Name and Addres		rd 655	W. Ba	ltimor	e Street
	1	23a. Part I. Enter the dis	/////	TXXX		I Ka	lltimore	. MD 21	201			Approximate Interval
Physician We dival Examiner	1	failure List only on Immediate Cause (Final or condition resulting in	ne cause on I disease	each line. a. <u>Compli</u>		of cu						Between Onset and Death
		Sequentially list condition	ons,	b								
	١ =	if any, leading to immed cause. Enter Underlying (Disease or injury that in	y Cause	с	consequence o							
cuted mnd transit	EXa	events resulting in death	h) Last	Due to (or as a								
O, e be executed ysician and burial - transit	edicai	X UNPENDED		AMENDED 23	a,27,28	Ba−f,pe	r ME g9	09 11/5/	10 TT	224	Date of delive	
c 6876 n certificat ending phy	nysician/m	IF FEMALE: 23b. Was decedent preg past 12 months?		1 Live b	ant at time of de	2 F6	etal death 3 ther (Specify)	Ectopic pregi	nancy		Date of delive Month	Day Year
Box the death y the atte	<u> </u>	1 Yes 2 No 9		9 OIIKIIO		esulting in the	underlying cause	given in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
P.O. es that signed be detact	≦								1 □ Y	es 2 🗸	No 3 Pro	obably 4 Unknown
Division of Vital Records, P.O. Boy To the Hospital or Attending Physician: The law requires that the deatt within 24 hours after death. To the Funeral Director: After this certificate has been signed by the att	Completed						-			opsy form <u>ed</u> ?	prior to death?	utopsy findings available completion of cause of
I Re	3	25. Was case referred to	o medical				26.Plac	e of Death (Chec		2 110		
Vita ysicial his cer direct	Ö	examiner? 1 ✓ Yes 2		Hospital: 1	npatient 2	ER/Outpatien	t 3 DOA	Other ₄ Nurs	sing Home 5	Residen	nce 6 🗸 Oth	er: Scene
ision of Vital Attending Physician: r death. ector: After this certif by the funeral director.	<u>=</u>	27. Manner of Death 1 Natural 5	Pending	Fd 0/	of Injury Day,Year)	28b. Time of Fd 10:		ury at Work? Yes 2 No	28d Describ subject his no	e how injur ct pu ck	ry occurred rposefu	ılly cut
Division all or Atto all Directo del in Directo led in by t	Certification:	2 Accident 3 X Suicide 6 [4 Homicide	Investig Could n determi	ot be 28e. Place	e of Injury - At h		et, factory, office	building, etc.	28f. Location or Town	(Street and State) 6 Pik	nd Number or R 940 Bro esville	tural Route Number, City ookmill Road , MD
spi hou y fil	Medical C	29a. Certifier 1 Cert	tifying Phys	lcian: To the bes	at of my knowled of examination a	lge, death occu	rred at the time, o	date and place, ar	nd due to the ca d at the time, da	use(s) and te and plac	manner as sta	ated. the cause(s)
To the within To the comple	Mec	29b. Signature and title	of certifier	and manner s	tated.		29c. Licen	se number		29d. D	ate signed (M	onth, Day, Year)
		0		~ <i>-</i>			0.0	.M.E.		Sept	tember 15,	2010
ĺ		30. Name and address of Donna M. Vinco			se of death (Iten Nedical Exar		1 Penn Stree	t, Baltimore,	MD 21201			
Sta Registr		31. Date filed (Month, D			egistrar's Signat	ure hav	V.I					
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DHMH 17 Rev 1/2001 OCME 2006 OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 2:40 AM Physician/ Month September 29ear Donald Jerome Miko, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Lutherville 5. Social Security Number 6. Sex last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 3 M 2 D F Menth, 08 Year) 1931 Months Davs Hours Min Pemhsylvania 213-26-9208 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Baltimore Kingsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? 23a Funeral with 21087 12201 Stoney Batter Road United States tems Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. а.ш. 14 Race - American Indian Black White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 Divorced 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Chemist Western Electric 29, 2010 any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Stephen Veronica Dvorchak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Victoria Miko /Wife 12201 Stoney Batter Road Kingsville, MD 21087 SEPTEMBER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Po 6t 01 cemetery, crematory or other place)
Chesapeake Crematory 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2010 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. National Address of End Funeral Alternatives M01443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Priysician/ disease or condition resulting in death) DUODENAL CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown g 🗌 Unknown sate has been signed bage 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗆 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 certificate filled in by the funeral director, 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? Hospital: 2 **X** No P 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred X Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed fil 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title 29d. Date gigned (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

JACKIE JONES,

31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CRNP

30838

3. Time of Death

10:27 PM

1 X Yes 2 □ No

Approximate Interval Between

Year

✓ DHMH 17 Rev 7/2009

Registrar

31. Date file (107h, 0ay 1/2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 24 2010 Virgil Wendell Miller /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Square da Balti more 7. Age (In yrs. last birthday) 05e Franklin Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 € M 2 □ F Michigan Director Oct. 13,1926 216-20-6317 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be rediffed at once. 1 ☐ Yes 2 🛛 No Baltimore Co. Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21206 United States 5519 Daybreak Terrace Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: WWTT 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify ≥ 3 Widowed 4 Divorced WWII White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) United States College (1-4or 5+) Elementary/Secondary (0-12) Government 2 Years 12 Years Special_ Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Yonell Miller Bertha Tivadar ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5519 Daybreak Terrace Baltimore, Maryland 21206 Mrs. Helen B. Miller (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 9/28/2010 Towson, Maryland 4 Donation 5 ☐ Other (Specify) Hilltop Service Corp.: 21. Signatus of Funeral Service Licens 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 80+ **Physician** /Medical Due to (or as a consequence of) Examiner Pulmonari SHEONIC OBSTRUC Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician for use as the buria' Physician/Medical yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 □No 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 → No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide within 24 hours at To the Funeral D completely filled is 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

CHILDEURIA PO Suite 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5-H.001E

9106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ EILEEN LUCILLE NELSON 28^{Day} 2010 ear MSEP 9:02 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 8. Date of Birth (Month, Day, August 4, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 X F Director Dakota 98 472-16-5735 August North Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 28a-f 1 Tes 2 No Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or Funeral <u> Avenue # C4</u>03 20815 Connecticut United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည should be Mary Grace McKay Peter John Antony 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau once. Page 1 and 2 3722 Bel Pre Road #12, Silver Spring, Maryland 20906 Curtis A. Nelson, Jr. / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, ☐ Burial 2 【XCremation 3 ☐ Removal from State October 2010 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc Bethesda, Maryland 21. Signature of Funeral Service Linensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Physician/ SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it is cause. Enter Underlying Cause (Disease or iinjury Examiner Due to lor as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Year Day ed by the a detached f 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 🗌 No Yes 2 X No 1 Tes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 **N**No <u>ا</u> 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accid work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier 🕵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the only one

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifie

mila

MELISSA S. BUTTS

31. Date filed **367** PO 1a2010

D.0

USN

MC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

0102202593 (VA)

29d. Date signed (Month, Day, Year)

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

30/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year М Gloria Naplachowski Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🕱 F Hours 11/07/77933 Baltimore, MD Yrs Director 212-32-0498 76 Usual Residence of Deceden 10b. County should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No Baltimore Lutherville Maryland 10e. Street and Number 5 10f. Zip Code 10g, Citizen of What Country? ms 23a or must be r Funeral U.S.A. 21093 8334 Tally Ho Road items 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Examiner Black, White, etc. 1 Never Married 2 🔀 Married 9 þ 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced "natural", Specify: White Completed Year or Dates er than "natur , the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) uit. Page 1 and 2 should be filed within street of Health and Mental Hygien ortant: If item 27 is marked other thingury or other traumatic event, the Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary C. Dr. Edward W. Zelinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8334 Tally Ho Road, Lutherville MD 21093 Stanley Naplachowski/ husband 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 09/30/2010 Towson, Maryland 22. Name and Address of Facility Signature of Funeral Service Licenses Towson, MD 21204 Ruck Towson Funeral Homé, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence on or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death been signed by the sales should be detached 1 ☐ Yes ∠ ⊭ g ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has ' page 2 s performed certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 욘 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? s after death. Certificate: 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month Day, Year) Registrar's Signati State 3 0 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month Year Nylander) = hn 1845 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)
 T i how is **Funeral** Months 1 🕱 M 2 🗆 F Days Hours January 3,1979 138-98-0351 Liberia **Director** 31 Yrs. Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Maryland Columbia . Howard 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6146 Starburn Path U.S.A. 21045 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married Completed by 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Student Medical School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John C. Nylander, Sr. Sarah Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Mother) 6146 Starburn Path Columbia, Maryland 21045 Sarah Nylander 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Columbia Memorial Park Clarksville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 10-8-2010 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road Inc. Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) hepato cellular Physician/ CONCOL Medical Due to or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cauce. E. ter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) this c Certificate: To 1 🔲 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours after death e Funeral Director: A bleted filled in by the fi Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Defining Physician: to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20066515 22 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

OCT 0 1 2010

M.O

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Paul Warren Pardus State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical Examiner September 16, 2010 0000 hrs Paul Warren Pardus 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 600 North Wolfe Street **Baltimore** 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 226-96-7482 1 X M 2 F VPF Vinia 1960 50 April 11, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show notified at once. 1 Yes 2 X No Remington iit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland riment of Health and Mental Hygiene.

or other traumatic arms Fauguier Virginia Director 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? U.S.A. 11741 Freemans Ford Road 22734 Funeral 11 Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc 1 X Never Married 2 Married 2 X No Yes Specify: Black 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Transportation Bus Driver Services 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Edward V. Davis Jean Cole 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11741 Freemans Ford Rd., Remington, VA 22734 Ronald A. Gibson (Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, Date crematory or other place) 1 X Burjal 2 Cremation 3 Removal from State Department Important: Remington, Virginia Oct. 2, 10 Hollywood Cemetery Donation 5 Other Specify. 22. Name and Address of Facility
Joynes Funeral
P.O. Box 3633, 21. Signature o Funeral Service Licens Home, Inc. VA 20188 Warrenton, un 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval /Medical Death a. Contact Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed sician/Medical attending physician for use as the burial UNPENDED AMENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o ፩ ۵. 1 Yes 2 No 3 Probably 4 Unknown Completed Records, certificate has been a 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: Scene 2 ER/Outpatient 3 DOA this 1 🗸 Yes 2 No 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 28b. Time of Injury Certification: Sep 16, 2010 Subject shot self Natural 1111 hrs Division 1 Yes 2 ✓ No 5 Pending Director: 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 600 North Wolfe Street, Baltimore, MD determined 24 hours a (Specify) Hospital 4 Homicide 29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Sal To the 2 📝 Medical Examiner: On the basis of examinatign and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medic and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 17, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D.

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Palmeri **Emma** Physician/ 2010 ам September Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Hospice 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Months (Month, Day, Year 03/28/19 Country) 201-24-2095 79 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Blair Altoona 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16602 USA 2605 Dove Avenue hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) be filed within 72 and Mental Hygiene.

Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Service Beautician traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Edna Gilda Sciarrillo ပ Michael Ross Petrogallo permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
23 Sugarvale Way, Lutherville, MD 21093 Michele C. Pearlman/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crem. 10/2/2010 Woodbine, MD 4 Conation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 2 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): ending physician are use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Por Month Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown ned by the a e detached f 1 ☐ Yes 2 g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I by Records, 2 X No 3 Probably 4 Unknown 1 Yes been six Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 Yes 2 No this certificate 25. Was case referred to medical Division of Vital director, 26. Place of Death (Check only one) Be examiner? 2 1 🗌 Yes 4 Nursing Home 5 Residence ည 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? 1 🗆 Yes 2 🗆 No injury Natural 5 Pending n 24 hours after death.

The Funeral Director: After the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the funct 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one within To the 29b_Signature and title of certifle

State Registrar

jDHMH 17 Rev 7/2009

OCT 0 1 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year,

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER Day 25, CLAIRE JOSEPHINE PRITCHER 2010 5:06 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER HARFORD BEL AIR 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign sep. 17 1 M 2 X F Director 1916 Pennsylvania 165-05-7923 94 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🎦 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 979 Phillips Place 21014 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Force 1 ☐ Yes 2 X No If Yes, Give Completed by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Education Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julius (nmn) Apanewicz Marianne (nmn) Grenda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan H. Waldhauser / Daughter 603 Millwood Dr., Fallston, Maryland 21047 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Air Memorial Gdn 10-1-10 Bel Air, Maryland 21. Signature of Funeral Service Licenses McConas Funeral Home, P.A. Marla <u>50 W. Bro</u>adway, Bel Air, MD 21009 23a. Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Multiorgan Systern disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Septic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine severe Preumoma The law requires that the death certificate be executed attending physician and I for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obstruction Small bowel 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No of Vital Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗹 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatere and title of certifier 29d. Date signed (Month, Day, Year) D63420 September 25,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) upper cherapeake Dr Bel AST MD 21014 500 KMaral 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Sephmber

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** VFtomor 050010 70 /Medical acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Yes Sept 30) The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year) 1 ★ M 2 - F 81 1928Maryland **Director** 217-20-4162 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. or 28a-f show notified at 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits MD 1√2 Yes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ò ral", or Items 23a o Examiner must be 5013 Herring Run Drive Funeral 21214 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 🔀 Married 0 Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Specify: black 150-53 "natural" Completed al Hygiene. d other than "nature went, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 5+ teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Robert Edward Patterson Blanch A. Williams ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Katherine Patterson/spouse 5013 Herring Run Drive Baltimore, MD permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. W 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street min 21201 Raltimore, MD 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (r as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last nding physician and use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate has performed? 1 Yes 2 🗌 No 2 No or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) Hospital: 2. No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day 1 Natural 5 Pending investigation Injury after death. Director: Aft 1 Yes 2 🗀 No 2 Accident completely filled in by the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours Hospital 29a. Certifier 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number

State Registrar KAUSTURITA PATEL NO
31. Date filed (North, Pay, Year) 1010 22. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

backs

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23artff, 23, 27, 28a partment of Health, 100 Mental by 18 in e = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 Physician/ M vitherine Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death mm9510 If Under 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗹 F Months Davs Hours Min (Month, Day, Director or items 23a or 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 M No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 320 enue 0 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. Armed Forces' þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give 3 Nidowed 4 Divorced Specify: Completed Year or Dates white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) iome ma Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughte 2120 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 A Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Sept 1, 2010 Kwood Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee apel & Cremation Services Harford Road Parkville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or relativatory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between se and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conquence of) Examiner ROVED & VALED ROLE EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (o attending physician and for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last CERTIFICATION ue to (or as a consequence of): Physician/Medical S Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 Yo Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hip Hracture 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 \square Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has blirector, page 2 s autopsy performe 0 DOY O Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? House Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this funeral 28a. Date of injury Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 X Accident injury 5 Pending 06/17/2010 Unknown Subject fell 1 Yes 2 **X** No Investigation filled in by the 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building. etc. (Specify) 28f. Location (Street and Number of Bural Route Number of City or Town, State) 8800 01d Harford Road, Parkville, MD 4 Homicide determined Assisted Living Facility hours Medical Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause completed (Check the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) Certifying Nurse fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date Name and address of person who completed cause of death (Item 23a) (Type, Print) US

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed

3 0 2010

Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Natasha Pettigr	ew	1- For State Registrar		of Maryland		artment o <i>rtificate o</i> i		nd Mental		Reg. No.2	nin	30848
Physici Medical Exam		1. Decedent's Name Natash							2. Date of De Month Septemb	ath		3. Time of Death 2230 hrs
		4a. Facility Name (i	if not institution, giv	e street and number)	ecti	igrew	• • • •	or Location of De		4c. (County of Death	1
Funeral	н	Prince Geor 5. Social Security N	rge's Hospital	ev 17 Aos	/In vre I	ast birthday)	Cheverly If Under 1 Ye	ear If Under 24	Jrn 10 Date of B		ince George	e's thplace (State or
Director		215.06.	2225	M 2 X F	30	Yrs	Months Da		^{4in.} 07.0		Foreig	
. da		Usual Residence of 10a. State	Decedent 10b. County		10c. City.	, Town or Locat	ion					10d. Inside City Limits
ne Maryland or 28a-f show any fifed at once.	Ė	MD	P.G.			everly						1 Yes 2 No
Maryla	Director	10e. Street and Nur				- -	10f. Zip Code			10g. Citize	en of What Cou	ntry?
ith the 23ª or	a Di	6303 In	wood St	reet	Ever in III	6 13 14/0	2078		Consider Volume 1	U.S		
death w r items	uneral	1 Never Marrie	ed 2 Married	Armed Forces?	No No			lispanic Origin? (an, Mexican, Pue		0- 11	White, etc.	can Indian, Black,
s after rral", o	by F	3 Widowed		If Yes, Give Year			Yes 2 🔀 N				pecify:	
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213 hould b nd Men is mari	일	19a. Informant's Na	me/Relationship (T	ype, Print)				et and Number o	r Rural Route Nu	mber, City	or Town, State	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shou injury or other traumante event, the Medical Examiner must be notified at once.		4 Donation 5 21 Signature of Fur	Other Specify: neral Service Licen		_1							hrmann, PA
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(Medical	i ili	failure. List only Immediate Cause (F	y one cause on ea	ch line. Multiple Injuries				g, odd, do odraida	or respiratory an	1030, 311000	c, or ricurt	Between Onset and Death
Examiner		or condition resulting		Due to (or as a consec								
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50, te be ex nysiciar	Medical	UNPENDED IF FEMALE:		AMENDED 23c. If yes, outcome	of pregr	ancy				224 (Date of delivery	
Ox 6876 eath certificate tatending phy for use as the	sician/N	23b. Was decedent p past 12 months?		1 Live birth		2 Fet	al death 3	Ectopic pregr	nancy		Date of delivery onth D	ay Year
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be excouted thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and impletely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ţi Çi	27. Manner of Death 1 Natural	5 Pending	28a. Date of Injury (Month, Day,Yea FOUND:	nr)	FOUND:		ıry at Work? Yes 2 ✔ No	28d. Describe Operator of	bicycle	struck by ve	ehicle
or Att	Certification:	2 Accident 3 Suicide	Investigation 6 Could not be	28e. Place of Inju	ry - At ho	0530 hrs me, farm, street	, factory, office	building, etc.	28f. Location (Street and	Number or Rur	al Route Number, City
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	(Check only	Medical Examiner:	an: To the best of my On the basis of exami and manner stated.								
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	-	30 Name and address	SS of person who	ompleted cause of dea	oll of	232)	O.C.	IVI. ∟ .		Septe	mber 22, 20)10
		Patricia Aron	ica-Pollak MD		•	,	111 Penn S	treet, Baltimo	ore, MD 2120	1		
Sta Regist	ate	31. Date filed (Month)	1 2010	32. Registrar's	Signatur	bares						
Kegist	-			A Partie A	· - 14	un	·					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month, **Physician** 0915AM eptember 26,2010 Freddie Lee Price /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner tai 405 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year Jun 01, 9. Birthplace (State or Foreign **Funeral** Year) Months Days Hours Min. 1 M 2 □ F 64 North Carolina 218-50-0896 1946 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the the first event, the the first event. Director 1 ☐ Yes 2 MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1108 Sonnye Lane 21801 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 72 hours after Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □Yes 2 No <u>م</u> If Yes, Give Year or Dates:\ Specify: Black 3 Widowed 4 Divorced trew Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Freelance nd Mental Hygien 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) uth and Mental F. Be Jesse Price Clara Spence ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar Bertha Cahn /Sister 2201 Christy Pl. Herndon, VA 20170 permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tra 20c. Location - City or Town, State 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland 2010 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. NaCrandation Fine Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Shock Immediate Cause (Final **Physician** WEEK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner week neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-tran resulting in death) Last attending physician weel Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 - Ectopic pregnancy ō in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached to 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ pha10paThu 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has page 2 s autopsy performed Dement 2 No 2 No 1 ☐ Yes Division of Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1∐ Yes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No the f within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 5 Hospital 1 🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical compl**e**tely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Agnes Hos Pital, Baltimore, MD, 21279 GEGNEHU 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 30850 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 1:30AM M September Stanley Roscoe Payne Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Hospice Casey House Montgomery Rockville 8. Date of Birth (Month, Day, Year) Sex 1 **X** M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. Director 97 577-09-3490 Washington. February Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 11403 Stonewood Lane 20852 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 X Widowed 4 □ Divorced Year or Dates. 1941 – 1948 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Pepco Vice President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည C.T. Carroll Suther Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Joyce/ Daughter 11403 Stonewood Lane, Rockville, Maryland 20852 20a. Method of Disposition
1 □ Burial 2 🔀 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Mcemelery crematory or other place) Montgomery Crematorium Inc. October 1.2010 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Lice 57 Wisconsin Avenue M00335 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Arterial Ventricular Block of Heart Weeks Third Degree disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a nonexquiring of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the cate has been signed by page 2 should be detacl Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Artial Fibrillation autopsy performed? Yes 2 No eral Director: After this certificate filled in by the funeral director, pag 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) 2 🔀 No Other: 4 🗆 Nursing Home 5 🗆 Residence 6 💹 Other (Specify) Hospice 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 💆 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier ٌ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) D37142 September 29, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

M.D.

OCT 0 1 2010

Coleman, 31. Date filed (Month, Day, Year)

32. Registrar's Signature

1355 Piccard Drive, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ . Month Kenneth Orlando Peeples September 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE WAShington Medical Center Burnie ANNE ARUNDEL Glen Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year Months Hours Min. Country 214-58-8543 Director Maryland Aug. Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location with the Maryland Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** MD Anne Arundel Glen Burnie 1 Yes 2 No 10e. Street and Number "natural", or items 23a or 10f. Zip Code 10g. Citizen of What Country? 299 Snowcap Court Apt. D 21061 United States within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Truck Driver Transportation Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ should be Orlando Franklin Peeples Anna May Woernlein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is Virginia Anderson / Aunt Summit Hill Court Apt. A2 Catonsville, MD 21228 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If if cemetery, crematory or other place) 1 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory Sept.28,2010 Glen Burnie, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine anding physician and use as the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform To the Hospital or Attending Physiciam: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Appatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatura 29c. License numbe 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSDITE State

DHMH 17 Rev 7/2009

Registrar

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AMEND ITEM#20b, perFH, G908, 1076/2010, WS

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 26, 2010 7:50A M Car1 Pulley Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Park Health And Rehab Center Catonsville Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex 1▲ M 2 ☐ F Nov. 9,1933 Days Hours 76 Yrs. MaryTand **Director** 215-32-9794 Usual Residence of Decedent show 10h County with the Maryland 10a State 10c. City, Town or Location notified at 10d. Inside City Limits Director Baltimore Lansdowne 1 Yes 2 No or 28a-f MD. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a United States 21227 4131 Hollins Ferry Road Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner Armed Forces? Black, White, etc. 1 X Never Married 2 Married Completed by Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Tailor Clothing Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Barnes Charles Pulley, Sr. [da May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hollins Ferry Road, Baltimore, Maryland 21227 Dorothy Kelley / Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory LLC Oct. 2, 2016 Glen Burnie, Maryland 20a. Method of Disposition Department of H Important: If ite any injury or ot 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) . Signature of Fer eral Service Licensee 22. Name and Address of Facility MBROSE FUNERAL HOME, INC. 4 Sulphur Spring Road, Arbutus, MD. 21227 un 28 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 g a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed' 2 🗌 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) . Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injurv 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1009 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30853 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Robert Lee Robinson, Sr. Physician/ September 28, 2010 4:15 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death
Baltimore County Stella Maris Hospice Timonium . Social Security Number 6. Sex 1 ☐ M 2 ☐ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 90 Days Jan. 24, 1920 218-10-1738 Baltimore, MD. Director Yrs Usual Residence of Decedent show 10b. County per it. Page 1 and 2 should be filed within 72 hours after death with the Maryland Der artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at one. 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County Sparks 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7 D Windmill Chase 21152 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. W.W.II 1 Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A Elementary/Seconday (0-12) Restaurant Owner Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Hillen Robinson Lillian Esther Ruth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr.Robert Lee Robinson, Jr. (Son) 2900 Monkton, Road Monkton, Maryland 21111 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State (Harford County) Forest Hill, Maryland Friday 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evais fureral Chapel and Cremation Services, Inc. 4 ☐ Donation 5 ☐ Other (Specify) oct.01,2010 Signature of Funeral Service Licensee Jeffrey L. Gair Fenceful Alternatives Funeral & Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093-2215 Lic.#M00677 23a. 7 . In fer/ne isean of or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PROSTATE CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): physician and sthe burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 K No 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) **HOSPICE** ၉ 1 Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural (Month, Day, Year) injury 5 Pending 1 Tes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) OCT 0 1 2010

State Registrar

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6:00 PM SUNDER RAO SHANTHA ESTHER 00 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death BALTIMORE all CHRIST 40SPICÉ CARE 10WSON 9. Birthplace (State or Foreign Country) INDIA If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 🗆 M 2 ቖ F (Month, Day, Ye 214-70-1403 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medic I Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director MD HOWARD WOODBINE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral BUCKS Run DRIVE USA 21797 15200 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: INDIAN 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) OFFICE ADMINISTRATIOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 ELIZABETH WALKER BABU SUNDER RAO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a SABBENA ALLEN - DAUGHTER Bucks DR WOODRINE, MD 15200 Rud Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Page 1 Department of Important; If it 1 Burial 2 Cremation 3 Removal from State 10/03/2010 ADELPHI 4 ☐ Donation 5 ☐ Other (Specify) CAPITOL MORTUARY FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARYLAND AVE NE, WASHINGTON DC 20002 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause to each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, in the sequential sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of th Examiner nsequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months? Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 💓 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has t autopsy 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: ≥ No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide
Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 29a. Certifier only one) 29b. Sigr tore and title of ce 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Brint) 701 31. Date filed (Month, Day, Year, State Registrar OCT 0 1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			. FOI	partment of Health and Mental Hy	/giene
	25			ertificate of Death	Reg. No. 0 10 30855
H	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Do Month	Day Year 8:15 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ı	- LAGITIII	CI	Future Care Sandtown N. H.	Baltimore	NIA
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		nth 9. Birthplace (State or Foreign Country)
-	Director		Usual Residence of Decedent	Narch	28,1914 Alabama
	ryland how		10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
	Ba-f s	Director	M) Na Ba	Utimore	1 €Yes 2 No
	with the or 2		10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ms 23	Funeral	11, Marital Status 12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (Specify Yes or N	o- 14. Race - American Indian,
٥	or Ite	Fur	Armed Forces? 1	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:	Black, White, etc. Specify:
215-0036	within 72 hours after death with the Maryland jiene. rthen "natural", or Items 23a or 28a-f show the Madical Examilitier is ust be inclifted at	d by	3 Wildowed 4 □ Divorced Year or Dates:		Black
ည် က	in 72 n "nat	Completed	(Specify only highest grade completed) (Gir	cedent's Usual Occupation we kind of work done during most of working . DO NOT use retired)	16b. Kind of Business/Industry
717	d with	Com	Elementary/Secondary (0-12) College (1-4or 5+)	Prisser	Archer's Laundry
and	be filed ntal Hygi of other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	e, Maiden Sumame)
_	should nd Men marke imatic	٩	19a. Informant's Name/Relationship (Type, Print) (Son) 19b. Ma	iling Address (Street and Number or Rural Route Numb	ber City or Town State Zin Code)
Mary	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		Mr. Melvin Stokes 305	10 AL I	Batto., ND 21216
Ze,	of Hea		20a. Method of Disposition 20b. Place of Dis	position (Name of Date rematory or other place)	20c. Location - City or Town, State
saltimore,			4 Donation 5 Other (Specify)	Mem. Park 10/1/2010	Arbutus, MD
Rail	permit. Pag Department Important: any njury c		21. Signature of Funeral Service Light see	22. Name and Address of Facility Joseph L. Russ Funer	el Home, P. A.
		_	23a. Part 1. Enter the disease, or complications that caused the death. Do not e		Balto, MD 21216 arrest, Approximate
	Pnysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition ALZHEMER'S	DEMENTIA	Interval Between Onset and Death
	/Medical		resulting in death) a		
	Examiner	<u></u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
-	nted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury		
Ď	be executed sician and burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence of):		
8/PU	ate hy:	dical	d		
٥ ×	leath certific attending p	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
ROX	d for u	Physician/Me	1 Live birth 2 Fetal death 3 in the past 12 months? 4 Pregnant at time of death 5	BDEctopic pregnancy Dother (specify)	Month Day Year
r Ö	the by th	hys	9 Unknown		
Ś	w requires that the s been signed by th should be detache		Part II. Other significant conditions contributing to death but not resulting in the		tobacco use contribute to the cause of death?
Ö	requi	eted	COKONARY ARTERY DISEAS		Yes 2 No 3 Probably 4 ☐Unknown
Kecord		Completed by	HYPERTENSIVE CARDIOVASCULA	PUSEASE 24a. Wa. auto per	opsy prior to completion of cause of death?
_		0	25. Was case referred to medical	1 ☐ Yes 26. Place of Death Check only	
5	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpate	Othor & a	
<u> </u>	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	how injury occurred
DIVISION	death ctor: /	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,	M 1 Yes 2 No	(Street and Number or Rural Route Number,
<u>≥</u>	al or A safter Il Dire	Certification:	4 Homicide determined building, etc. (Specify)	City or To	own, State)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, (29a. Certifier (Check only (Check only Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place, and due to the	e cause(s) and manner as stated.
	the P thin 24 the P implete	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	F3F8		M·D	D0059107	09-29-2010
	3		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	
	~		KAZU UMA 210 BUSINESS CS	enter drive, reisters	Town, mo 21136
	Sta Registr		31. Date filed (Month Day, Year 1010) 2. Registrar's Signature 2. Registrar's Signature	ill	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#20b, c. perFH, G908, 10/7/2010, WS State of Maryland/ Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month FWARI Year BARKA 2010 Medical Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death timore 8. Date of Birth (Month Day Ye 9. Birthplace (State or Foreign Funeral Months 1 🗆 M 2 💢 F **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 □ No nore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) lementary/Seconday (0-12) College (1-4 or 5+) SKNOWN Be 17. Father's Name (First, Middle, Last) egraqui 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) afacette 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Ring Memor 21. Signatur, of Funeral Service V censee M0155 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Ph, sician/ Cardiac Arry Thuris disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner esten 3 ean Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe Yes 2 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital Other: 1 Yes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 🗌 Yes 2 🗌 No Accident Investigation the f Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1-005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. HANOVER STREET, BAGMD-21225 RATIBHA 300 HARMA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

10-07437 William Richard Staffa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 30857

		1- For State Registrar			Certific	ate of L	Death				Reg. No	D .		
Physici Medical Exami		1. Decedent's Name (First, N WILLIAM R.								2. Date of De Month Septemb	eath Dav	Year		3. Time of Death 1600 hrs
*		4a. Facility Name (if not insti 3103 Woodhome F		and number)			-	or Location City	of Death			c County o Balti		e City
Funeral Director		5. Social Security Number 144–66–9905	6. Sex		In yrs. last birl 48	thday) Yrs.	Months D	ear If Und	ler 24Hrs. s Min.	8. Date of B			Foreign	hplace (State or n untry) N . J .
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h the Mary 3a or 28a	Director	10e. Street and Number 3103 Woodhome	Road				Of, Zip Code	• 21234			10g. Ci	tizen of Wha USA		itry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4	Married Arm	as Decedent Evned Forces? Yes 2/X	erin U.S.	If Yes,	specify Cut	Hispanic Ori oan, Mexicar No s <i>pecify</i> :	n, Puerto I	ecify Yes or N Rican, etc.)	lo-	White,	etc.	can Indian, Black,
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6 72 ho in "na	lete	Elementary/Secondary (0-		ege (1-4 or 5+)		during most	of working I	life. DO NOT	use retire	ed)				,
within jene.	Completed	12 yrs.	, ,	yrs.	Y	outh /	Advoca						0r	ganization
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than aumatic event, the Medical	a	17. Father's Name (First, Mid Joseph Staff	3		.			Jun	e Mai					
MD 2 and 2 should alth and M m 27 is m aumatic c	2	19a. Informant's Name/Relati Gail Gordon 20a. Method of Disposition		t)	8:	30 Bla	auvelt	St.		urai Route Nu r Vale	N.J	. 07	675	
Baltimore, permit. Pages I an Department of Hea Important: If itel		1 Burial 2 Crema 4 Denation 5 Other		oval from State	20b. Place of cremato Metro	or Disposition Ory or other CIEM	place) atory,	Inc.	9-29	Date 910		Location - C		
Balti permit. Departi Importi injury o		21. Signature of Fune all Sev	ce/Livensee			22. Nam Las 740	e and Address ann Sahn 1 Bel	ess of Facility Funeri	al Ho	ome ltimor	e. I	Md. 21	1236	3
Physician √/Medical	/4	failure. List only one cau	0 1			t enter the r	mode of dyin	ng, such as c	ardiac or	respiratory a	rest, sh	ock, or hear	t	Approximate Interval Between Onset and Death
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	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cau	se	r as a consequ	ence of):								\dashv	
d d d d	Examine	(Disease or injury that initiate events resulting in death) La		r as a consequ	ence of):									
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876(tificate ng phys	M/M	IF FEMALE: 23b. Was decedent pregnant in		yes, outcome o Live birth		Fetal o	death 3	B Ectopic	o pregnan	cv	23	d. Date of do	elivery Da	ay Year
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi			Physician: To the caminer: On the band man											
F % F 3	ž	29b. Signature and title of cert		57/1	1/10	30		.M.E.				Date signed		h, <i>D</i> ay, Year)
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Registr	ar	70. 0 1 2010	The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa		7									

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 30858 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 28, 2010 Nancy Lynne Shircliff 10:50 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Harford Upper Chesapeake Medical Center Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year 1935 1 DM 2 XF Days Hours June 13, Maryland 213-32-4292 Director 75 Usual Residence of Decedent 28a-f shov filed within 72 hours after death with the Maryland at Hygiene.

1 other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Harford Bel Air 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21014 USA 555 S. Atwood Road Apt. 208 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: White Completed 3 Widowed 4 Divorced or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene Important if item 27 is marked other the any injury or other traumatic event, the Jonce. Medical Transcriptionist Radiology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Margaret Coppersmith William Ernest DeGrafft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John F. Davey / Husband 555 S. Atwood Rd., Apt. 208, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Service Corp. 9-30-10 Towson, Maryland Funeral Service Licensee ²² Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ pheumon disease or condition resulting in death) Medical Examiner Sequentially list conditions if cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consuluence of that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Unknown Unknow 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No Yes 2 X 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 10 No Other: မ 1 Unpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1"Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical 1 Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Lrina Mikit

31. Date filed (Month, Day, Year)

anskayam.D.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician/ Month Dorothea Shanks p_{M} Sept 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 4K Gardenway Greenbelt 8. Date of Birth (Month, Day, Year, 7/26/1920 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 1 □ M 2 🙀 F 90 Director Yrs 357-14-7445 Germany Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director or 28a-f sl Prince George's 1 Ves 2 No MD Greenbelt 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 20770 4K Gardenway **ŪSA** 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 2 **N**0 Maryland 21215-0036 Yes, Give 1 Yes 2 No Specify: White Specify: "natural", 3 Widowed 4XXDivorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Laboratory Technician Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elsa Seligsohn ဂ္ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e Ernst Brasch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 418 Boston Ave. Takoma Park, MD 20912 Oliver Shanks, son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) George Washington Cem. 10/1/2010 Adelphi, MD 21. Signature of Funeral Service License MO1539 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death 2 🔀 No cate has been signed by the page 2 should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. . 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No ျှ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural 5 Pending injury Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland	-			/lental Hyg	giene	0 20260
			State Registrar	-0	Cer	tificate of L	Death		Reg. No. 4	0 30860
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	Examin	er	4a. Facility Name (if not institution, give	Nursing & Re	heb	4b. City, Town, or	Location of Death		4c. County of De	eath
	Funeral Director		5. Social Security Number 213-76-5838 6. S	ex Z/Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Mar 28	Year) 9. E 1929 Ma	Birthplace (State or Foreign Country) ryland
	nd now at	_	Usual Residence of Decedent 10a. State 10b. County	10c, City,	Town or Loc	eation				10d. Inside City Limits
	larylar 3a-f sl ified	ecto	MD	В	altimo	ore				1 √ Yes 2 □ No
	the N	ΙΩ	10e. Street and Number	•		10f. Zip Code			10g. Citizen of What (Country?
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36	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1X Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔼 No If Yes, Give	If	vas Decedent of H f Yes, specify Cuba Yes 2 🛣 No	ispanic Origin? (Spin, Mexican, Puerto Specify:	Rican, etc.)	14. Hace - An Black, Wh Specify:	nerican Indian, nite, etc. white
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Maryland 21215-0036	ild be filk Mental larked c	2					_	,	·	
Mar	and 2 should be Health and Metem 27 is mark		19a. Informant's Name/Relationship (7) Shelly Anderson/			,			; City or Town, State, . e , MD 2121	
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State 20b. Pla	ace of Dispo	sition (Name of natory or other place	- 1	Date	20c. Location - City	
altin	permit. Page Department o Important: If any injury or once.		4 ☐ Donation 5 📉 Other (Speci	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	S ²²	. Name and Addre	ss of Facility Omv Board	655 W.	Baltimore	Street
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(687	ath certificate be executed attending physician and for use as the burial-transit	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan	icy death 3	Ectopic pregnan	cv		23d. Date of	•
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Division of Vital	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						street and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number or and Number of Number or and Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Numbe	Hurai Houte Number,
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	To the within To the compl	Σ	20b Signature and title of certifier		Kilowiedge,	29c. Licens			29d. Date signed (Mo	
D			Domotur H		20.17	101	5500		4 24	2010
			30. Name and address of person who	completed cause of death (Item	DOL	PHINS	51, BI	LTIM	CRE, M	021211
	Sta Registr		31. Date file OCT, 0ay 1 2010	32. Registrar's Signatu	bar	Less .				v

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar 30861 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Judith A. Vaughan 572 EMBER 26 2010 2.37A M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death County of Deat GUEN BURNIE BAUTIMUME WASHINGTON MEDICAL CENTE Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Months Country) Mary Land 1 M 2 XF Hours Director 67 217-40-5067 Jan. Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "---- any injury or other than." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Dunda1k 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2042 Shore Road 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married Yes 2 🔀 No 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Years Retail Salesperson J.C. Penney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Clarence E. Schweiger Rita Marie Cyphert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steve Vaughan (Son) 2042 Shore Road Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1[™] Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Ht. of Jesus Gem. 9/29/2010 Dundalk, MD ²² Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ METACTATIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of, Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? eral Director: After this certificate filled in by the funeral director, pag 2 No 2 N Yes To the Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 🗌 Yes 2 3 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

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Glen Burne

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

			1 - For State of M	aryland /	-	artment of F <i>tificate of E</i>		-	giene Reg. Nd:-	0	30862
	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Viola Woodward					2. Date of Dea Sept.	_	Yr 10	3. Time of Death 6:20am M
	Medic Examir		4a. Facility Name (if not institution, give street and number)			4b. City, Town, or	Location of Deat		4c. County o		U. ZUAIII W
.,		Ш	Fairhaven Health Care Cen 5. Social Security Number 6. Sex 7. Ag		-41 -1- · · ·	Sykes If Under 1 Year	ville If Under 24 Hrs	Ta 5 (5):		roll	
	Funeral Director		299-16-9496 ^{1 □ M 2} 🟋 💮	e (In yrs. last bi 90	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day Aug 14	, Year) 1920	9. Birthpi Counti	lace (State or Foreign ry) OH
	and Show	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Loc	ation				10	Od. Inside City Limits
	Maryle 28a-f	irect	MD Carroll			Syk	esville				1 ☐ Yes 2 🎇 No
	e filed within 72 hours after death with the Maryland tal Hygiene. tal Hygiene. do dother than "natural", or items 23a or 28a-f show od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	Funeral Director	10e. Street and Number 7200 Third Avenue			10f. Zip Code	784		10g. Citizen of WI		try?
	death v		11. Marital Status 12. Was Decedent Armed Forces?		13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race		
036	rs after ral", or Exami	Completed by	1 X Never Married 2	No	1	☐ Yes 2 🔀 No	Specify:		Specify:	Whi	
Maryland 21215-0036	72 hou n "natu fedical	nplet	15. Decedent's Education (Specify only highest grade completed)		(Give k	ent's Usual Occupa ind of work done of NOT use retired)		rking	16b. Kind of Bus	iness Ind	ustry
212	within giene. rer tha t, the I		Elementary/Seconday (0-12) College (1-4 or 5	i+)		hematici	an		US Gove	rnme	nt
and		To Be	17. Father's Name (First, Middle, Last) Stanley Woodward						Maiden Sumame)		
ary	2 should be fi th and Mental 27 is marked traumatic ev		19a. Informant's Name/Relationship (Type, Print)	19	b. Mailin	g Address (Street a		de Span		te, Zip C	ode)
	1 and 2 s if Health s item 27 i		Mr. Damian Halstad, Execut			Court S	t., West	minster,			
More			20a. Method of Disposition 1	cemete	ery, crem	sition (Name of natory or other plac rove Ceme	/	7/2010	20c. Location - C		
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	100764	22.	Name and Addres	s of Facility HA	IGHT FUN	ERAL HOM		CHAPEL, PA
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	Medical Examiner		Sub	a consequence	of):	emovr	hug R			2	O days.
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Consequence			4			رز	O days
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09/	To the hospital or Attending Priysician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Directors After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	d							\perp	
χ ×	n certiff tending r use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome 1 ☐ Live Birth		th 3 🗆	Ectopic pregnanc	v		23d. Date		
. B 0X	ne deat y the at iched fo	Physician/N	1 Yes 2 No 9 Unknown	time of death	5 🗆	Other (specify)			Mont	л [Day Year
т. О	es that ti igned b	þ	Part II. Other significant conditions contributing to death b	ut not resulting	in the ur	nderlying cause giv	en in Part I.		bacco use contrib		
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VItal	/sician: s certific director,	To Be	25. Was case referred to medical examiner? 1 → Yes 2 □ No Hospital:	ent 2 ER/O	utnation	Totho	r:		ence 6 🗌 Other	(Passifu)	
101	ung Pn 1. After thi funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Day	y 28b.	Time of injury	28c. Injury work	at	28d. Describe h	ow injury occurred		00-10
DIVISION	Attencer death ector: by the	ertificate:	3 Suicide 6 Could not be 28e. Place of Inju		arm, stre		Yes 2 X No	28f. Location (S	treet and Number n, State) 720	or Rura F	Route Number,
<u>ב</u>	pural or curs aft eral Dir filled in	O	29a. Certifier 1. Certifying Physician: To the best of	n	OM		data and place a	SyKo	5 Ville 1	10	21734
:	ine Hos nin 24 h the Fun pleted	Medical	(Check only one) 3 Certifying Nurse Practioner: To the	kamination and/	or investi	gation, in my opinio	n, death occurred	at the time, date ar	nd place, and due to	o the caus	se(s) and manner stated.
	Mith Con		29b. Signature an wittle of cartiflar	D14	N	29c. License		10051924	Septem b	Month, Da	ay, Year) 30,2010
			30. Name and address of person who completed cause of do	ath (Item 23a)	(Type, Pr	herry R	34 E	ders bu	5 MD	2	30,2010
	Stat Registra	e ir	31. Date filed (Month, Day, Year) 32. Registra	ris Signature	Red	V					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death - 2<u>3</u>, Physician 2010 September 8:48 AMM Viola G. Waldron /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 916 Elm Ridge Avenue Baltlillore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Months | Days | Hours | Min. | Nov 4, 1916 Baltimore Baltimore 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖾 F Months 217-32-4931 93 Director England Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evented 2000. 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 916 Elm Ridge Avenue 21229 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 24 If Yes, Give Year or Dates: 1 Never Married 2 Married ò 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Nidowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) unk 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) blue printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank George Collings Amy Beatrice Collins ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 916 Elm Ridge Avenue Baltimore, MD Carmelita Malivat/granddaughter 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wage , Wirector state Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EMENTIA SENILE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Year Dav 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending

law requires that the death certificate be executed and burial-trar Division of Vital Records, P.O. Box 68760, attending physician for use as the buria signed by the a director, page 2 should b Hospital or Attending Physician: The this funeral c After death. within 24 hours after death To the Funeral Director:

completely filled in by the Medical

Certification:

29a. Certifier (Check only one)

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

investigation

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

29c. License number

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GORMAN ROAD

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9'31 AM bembes 2010 Medical Pamela L. West City, Town, or Location of Death Facility Name (if not institution, give street and number) 4c. County of Death Examiner 0) Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** unl July 30, Year 1956 1 □ M 2 🂢 F Months Days Hours Min WasHTigton DC Director 54 Usual Residence of Decedent show 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits with the Maryland Ħ Director or 28a-f sl 1X Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö "natural", or items 23a or edical Examiner must be r Funeral 3700 Greenspring Avenue #811 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates white Completed 3 Widowed 4 X Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha unk housewife own home Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) it. Page 1 and 2 should be fill thrent of Health and Mental rtant: If item 27 is marked outury or other traumatic ew 2 James B. West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2. Department of Health Important: If item 27 any injury or other tr Mike Hudson/friend 16411 Mt. Calvert Road upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 □ Donation 5 類 Other (Specify) in state 21. Si mat of Funeral Service Licen State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Gastro intestinal Onset and Deal Immediate Cause (Final Lower Physiciani Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner sta equires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consi quence of) the burial attending physician Physician/Medical Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) be detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an The law has Melltus performed? Yes 2 No 20 After this certificat or Attending Physician: Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 10 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: At completed filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 14 🕳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2. only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of I	Maryland	-	artment of		and M		2 (110	20065
	-		Registrar 1. Decedent's Name (First, Middle	/ ast)		Cer	tificate of	Death	Т	2. Date of Dea	Reg. No.		3. Time of Death
	Physicia		Julius Charle									29 ^{Year}	2010 2:38 PM
	Medic Examir		4a. Facility Name (if not institution, 8207 Bullneck	-	r)		4b. City, Town,		of Death		4c. Count	ty of Dea	
	Funeral Director		5. Social Security Number 217-38-5134	6. Sex 1 M 2 □ F	Age (In yrs. Ia 68		If Under 1 Yea Months Days		24 Hrs. Min.	8. Date of Birth (Month, Day OCT 13	Year) 1941	9. Bii	rthplace (State or Foreign Juntry) laryland
	d d	١.	Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	ation						10d. Inside City Limits
	arylan a-f sh fied a	Director		timore		undalk							1 Yes 2 No
	or 28	ă	10e. Street and Number				10f. Zip Code				10g. Citizen of	What C	
	with t	Funeral	8207 Bullneck	Road			212	22			Unit	ed s	States
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ∰ Divorced	If Van Civa	s? No	l:	Vas Decedent of f Yes, specify Cul	oan, Mexican	, Puerto F	cify Yes or No- Rican, etc.)		ack, Whit	erican Indian, te, etc. White
Maryland 21215-0036	thin 72 hour sne. than "natu se Medical	Completed by		nt's Education st grade completed) College (1-4 c	or 5+)	(Give I life. Di	lent's Usual Occu kind of work done O NOT use retired penter	during most	t of workin	gg	16b. Kind of I		sIndustry
land 2	be filed within 7 ental Hygiene. rked other than ic event, the M	To Be (17. Father's Name (First, Middle, L George Thomas	*		Cai	pencer	1		(First, Middle, Mine Gra	Maiden Surnan		
	and 2 should be file Health and Mental I tem 27 is marked o ther traumatic eve		19a. Informant's Name/Relationsh Cassandra Wat		ter		g Address (Stree 188 Park					-	. ,
Baltimore,	Page 1 an nent of He ant: If iten ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S		ate C6	emetery, c re n	sition (Name of natory or other pl ce Cremat			oct 01,	20c. Location	-	r Town, State le, Maryland
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service L	icensee	M0144	3 22	Name and Add Cremati 8717 Gr						land 21286
	Physician/		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that caus only one cause on each l	sed the death line.	n. Do not ente	r the mode of dy	ing, such as	cardiac or	respiratory arre	est,		Approximate Interval Between Onse an D th
	Medical Examiner		resulting in death) Sequentially list conditions,	Due o or a	as a consequ	ence of):							
	uted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	с	as a consequ								
09	ate be executed physician and the burial-transit	dical E	resulting in death) Last	Due to (or a	as a consequ	ence of):							
6876	rtifical ing ph e as th	Mec	IF FEMALE:										
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ta	ysician: is certific director,	Be	25. Was case referred to medical examiner?	Hospital:				Place of Dear	th (Check	only one)	7		
fΝ	Physi this c	<u>P</u>	1 Yes 2 No 27. Manner of De h	1 Inp	atient 2 1	ER/Outpatien 28b. Time of	t 3 🗆 DOA 28c. Inju			ne 5 Reside			cify)
ion o	tending death. tor: After the funer	Certificate:	1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	g (Month, L	Day, Year)	injury	M 1	rk? Yes 2 🗆	No	8d. Ďescribe ho			
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral		4 Homicide determ	ined 286. Place of I building,	etc. (Specify)		eet, factory, office			City or Town	n, State)		ural Route Number,
	To the Hosp within 24 hor To the Fune completed fi	Medical	(Check 2 Medical E only one) 3 Certifying	Physician: To the best xaminer: On the basis o Nurse Practioner: To the	f examination	and/or invest	igation, in my opli leath occurred at	ion, death oc the time, date	curred at 1	the time, date an	nd place, and d	ue to the	cause(s) and manner stated.
	To To		29b. Signature and title of certifier	M CK	24)	RI	se number	26	3	29d, Date sign	n b	th, Day, Year)
)			30, Name and address of person of	Sch CRn	PG	701 /	V.Ch	ries.	S+.	70 W	an m	7)	21204
	Sta Registra		31. Date filed (Month), De Very	Annua 32. Regis	stra s Signar	all		-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Mar		artment of H		lental Hy	giene Reg. No.	10 30866
	Dhusisis	/	Decedent's Name (First, Middle, Last)				2. Date of De Month	nth.	3. Time of Death
	Physicia Medic	al	John Joseph Wnuczek				Septem		2010 2:45 A M
الم	Examin	er	4a. Facility Name (if not institution, give street and number) 10101 Frederick Avenue			Location of Death		4c. County	of Death gomery
	Funeral		5. Social Security Number 6. Sex 7. Age (//	n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birthplace (State or Foreign
	Director		215-38-3481 ^{1 ™ M 2 □ F}	95 Yrs.	Months Days	Hours Min.	January	20, Year) 20, 1915	Wisconsin
	nd how a t	٦٢	Usual Residence of Decedent 10a. State 10b. County 1	0c. City, Town or Loc	cation				10d. Inside City Limits
	Aaryla 8a-f s tified	rect	Maryland Montgomery		Kensing	ton			1 🌠 Yes 2 □ No
	death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director	10e. Street and Number		10f. Zip Code			10g. Citizen of V	What Country?
	th with ms 23 must	iner	10101 Frederick Avenue	Line Line		0895	<i>y y y</i>		ed States
_	or iter	by Fu	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Eve Armed Forces? 1 ☒ Yes 2 □ No	er in U.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto l	city Yes or No- Rican, etc.)	14. Raci Blac	e - American Indian, k, White, etc.
2	irs afte iral", Exar	ed b	3 X Widowed 4 ☐ Divorced If Yes, Give Year or Dates. WW	1 1	☐ Yes 2 🛣 No	Specify:		Specify:	White
2	"natu edica	plet	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupa	ation uring most of worki	ng	16b. Kind of Bu	usiness Industry
9500-61212	within 7 /giene. ner than t, the M	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	l .	O NOT use retired) untant			Governm	nent
פר	B f to to	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle,		
<u>Ya</u>	should be file and Mental 7 is marked or raumatic eve	잍	Albert Wnuczek			Helen K	laman		
Maryland	ge 1 and 2 should be nt of Health and Men If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type, Print)	I	•	nd Number or Rura			
δ, -	l and the litem 2		James Wnuczek/Son 20a. Method of Disposition	20b. Place of Dispos	sition (Name of	.ck Avenue	Date		City or Town, State
Ē	Page 1 nent of int: If i		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Gate of H Cemete	natory or other place eaven	e) Octobe	er 5, 010		Spring, Maryland
saltimore,	permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra	100	21. Signature of Funeral Service Licensee	RO.	Name and Addres				ethesda- nevy Chase Inc. laryland 20814
	20 E # 9	10							
k	in the second		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ie death. Do not ente	r the mode of dying	g, such as cardiac o	r respiratory ar	rest,	Approximate Interval Between Onset and Death
	নাysician/ ুMedical		disease or condition resulting in death) Aortic S Due to (or as a co						10 Years
	1 xaminer	L	Sequentially list conditions, b.						
	p iti	nine	if any, leading to immediate Due to (or as a co	onsequence of):					
	be executed sician and burial-transit	Exar	Cause (crisease or injury that initiated events c. Due to (or as a cr	onsequence of):					
2	cate be executed physician and sthe burial-transit	dical Examiner	d			<u>-</u>			
2/20	rtificat ing ph e as th	Mec	IF FEMALE:						
DOX	ath ce attend for us	cian,	23b. Was decedent pregnant in the past 12 months? 1 Live Birth 2 Pregnant at tire	Fetal death 3	Ectopic pregnancy Other (specify)	у		23d. Dai Mo	te of delivery nth Day Year
Ď	the de	Physician/Me	1 Yes 2 No 4 Pregnant at tir 9 Unknown 9 Unknown	ine or dodain o E					
7. 5	s that gned b	by P	Part II. Other significant conditions contributing to death but r	not resulting in the u	nderlying cause give	en in Part I.	1 _		ibute to the cause of death?
SD	equire een si nould	eted							3 Probably 4 Unknown
ecords,	e law r has t ge 2 sl	Completed					24a. Was autor perfo	osy F	Were autopsy findings available prior to completion of cause of death?
7	an: The	Be Co	25. Was case referred to medical		26. Pla	ace of Death (Check		ormed?	Yes 2 No
N Ed	nysicia nis cer direct	10 B	examiner? 1 X Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 ER/Outpatien	Othe	Pr .		dence 6 🗆 Othe	er (Specify)
5	ling Pl		27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of injury (Month, Day, Young) (Month, Day, Young)	'ear) 28b. Time of injury	28c. Injury work	?	28d. Describe h	ow injury occurre	ed
NISION	Attend death ctor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	- At home, farm, stre		Yes 2 □ No	28f. Location (9	Street and Number	er or Rural Route Number,
5	tal or / s after al Dire		4 Homicide determined 200. Flate of injury building, etc. (\$		•		City or Ton		
	Hospit 14 hour Funer ted fill	edical	29a. Certifier 1 X Certifying Physician: To the best of my (Check 2 Medical Examiner: On the basis of exam	knowledge, death o	ccured at the time, igation, in my opinion	date and place, and n, death occurred at	d due to the ca the time, date a	use(s) and manne ind place, and due	er as stated. to the cause(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	ž	only one) 3 \(\subseteq\) Certifying Nurse Practioner: To the best 29b. Signature and time of certifies	st of my knowledge, d	eath occurred at the 29c. License		e, and due to th		nner as stated. i (Month, Day, Year)
			· Mondon		D3797	75		Septeml	per 30, 2010
X	\		30. Name and address of person who completed cause of deat				2	1 1	1 1 00017
	Stat	e	Jeffrey P. Indrisano, M.D., 31. Date filed (Month, Day, Year) 32/Registrar's	Signature		ve #401,	Bethes	da, Mary	yiand 2081/
	Registra		OCT 0 1 2010 Serve	A. pa	Me				

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene state Amend Items 25,27,28a-f per me,g908.10/01/2010dhb Certificate of Death Reg. No. 30867 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sep Wolpert muriel 12:26 PM 6 Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Baltimore Count Randallstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🖵 F Months Hours 0572471922 Director 88 NJ 230-30-7341 Usual Residence of Decedent · 28a-f shov 10a, State 10b. County Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director BALTIMORE OWINGS MILLS 1 🗌 Yes 2 🛚 No MD 10e. Street and Number 10f, Zip Code 9 10g. Citizen of What Country? Funeral **23**a 4730 ATRIUM COURT, #172 USA 21117 items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. Completed by 1 X Never Married 2 Married ò Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 Widowed 4 Divorced WHITE . Page 1 and 2 should be filed within 72 hours tment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur jlury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) UNITED CEREBRAL PALSY Elementary/Seconday (0-12) College (1-4 or 5+) 12 OF NASSAU COUNTY, NY RECEPTIONIST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည NATHAN WOLPERT ETHEL GOLDBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARTHUR LEADERMAN/NEPHEW 4322 WOODBERRY ST, UNIVERSITY PARK, MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o XBurial 2 ☐ Cremation 3 X Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) N.ARLINGTON JEWISH 09/19/2010 NORTH ARLINGTON, NJ 21. Signature Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Acute myocardial Infarction Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Caquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Examine Due to (or as a consequence of): CERTIFICATION APPRIVED BY MEDIC The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\sum \) Yes 2 \(\sum \) No Day 5 Other (specify) Year g 🗌 Unknown ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Acute Renal Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed?

1 Yes 2 No this certificate 1 Yes 2 No of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 X Yes Other: 1📈Inpatient 2 🗌 ER/Outpatient 3 🔲 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Subject fell Director: After or Attending Netural
2 A Accident work? 1 ☐ Yes 2 X No 5 Pending ivision 3:45 p.M out of bed. 09/13/2010 Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4730 Atrium Ct. #1/2, Owings Mills,MD determined Assisted Living Facility within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of my knowledge doubt a state of my knowledge and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge doubt a course of the three date of place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier Sep 16, 2010 D70334 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
283 Smith Ave, Swite 2.3, Baltimore, MD 31. Date filed (Month, Day, Year) Regis State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death September 26, 2010 Physician/ 3:44 P M Susan Marie Wilkinson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carrol1 6905 Pine Hill Court Marriottsville Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex If Unde 8. Date of Birth **Funeral** Jan. 28 Days Min ^{Year)}19<u>62</u> 1 □ M 2 🕅 F 48 216-17-4497 MD Director Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Marriottsville 1 ☐ Yes 2X No Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 6905 Pine Hill Court United States 21104 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4X Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Healthcare** Receptionist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irene UKN Joseph Lease 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1979 Oak Hills Drive, Hanover, PA 17331 William Wilkinson, IV 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Crest Tematory or other place) 1 Burial 2 Cremation 3 Removal from State 9-30-2010 Marriottsville, MD 4 Donation 5 Other (Specify) Memorial Gardens Signatur 22. Name and Address of FacilitAmbrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) signed by the a ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b lirector, page 2 s autopsy performed death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: ည 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home & Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this leted filled in by the funeral di Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred ë 1-Natural 5 Pending work? Certificat 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar 32. Registras's Signature

101

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

eremy Joseph		1- For State Registrar	otate of Maryland	-	rtment of F tificate of D		a ivientai		eg. No.	30869
Physici Medical Exam		Decedent's Name (First, Mid			T.I.	11.		2. Date of Dea Month	nth Day Year er 26, 2010	3. Time of Death 0745 hrs
		4a. Facility Name (if not institut	cemy Jo tion, give street and number	oseph ^{er)}	Wa. 4b.		Location of D		4c. County of Dea	ath
		2801 Page Drive	6. Sex 7. A			Dundalk	Tretto-de-co	die Top 1 (p)	Baltimore Co	
Funeral Director		5. Social Security Number 212-23-2591 Usual Residence of Decedent	1 M 2 F	Age (In yrs. Ia		f Under 1 Yea Months Day			19,1988	
any		10a, State 10b, County	y	10c. City,	Town or Location					10d. Inside City Limits
Aaryland 28a-f show 1 at once.	tor		imore			undalk				1 Yes 2 X No
and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygione. teanth and Mental Hygione. tean 27 is marked other than "natural", or items 23a or 28a-f shorrammatic event, the Medisal Examiner must be notified at once.	I Director	10e. Street and Number 2801 Page Dri				Of. Zip Code	21222		Og. Citizen of What Co	ates
eath wi	Funeral	11. Marital Status 1 X Never Married 2 I	Married 12. Was Deceder Armed Forces 1 Yes	nt Ever in U.: s? 2 No				(Specify Yes or No erto Rican, etc.)	14. Race - Ame White, etc.	erican Indian, Black,
after d	by Fi		ivorced If Yes, Give Year or Dates:			s 2 No			Specify:	White
136 hin 72 hours afte e. than "natural", edical Examiner		15. Decedent's Education (Sp Elementary/Secondary (0-12			16a. Decedent's l during most		ion (Give kind DO NOT use		16b. Kind of Busines	s/Industry
036 ithin 7. ne. r than	Completed	12 Years	, , , , , , , , , , , , , , , , , , , ,	,	Lab	orer			Constru	ction
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle	_{e, Last)} narles Walk					ame (First, Middle, I	Maiden Surname) h Stawsky	
212 ould be Menta marke	To Be	19a. Informant's Name/Relation			19b. Mailing Ad	Idress (Stree			nber, City or Town, Sta	te, Zip Code)
MD nd 2 sho alth and m 27 is		Mrs. Deborah	R. Walk (Mot			age Dr		undalk, M		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		20a. Method of Disposition 1 Burial 2 X Crematic	on 3 Removal from S	State C	Place of Disposition rematory or other	place)		Date	20c, Location - City of	
nit. Pagartment ortant		4 Donation 5 Other 5 21. Size re of Funeral Service		Ho	11top Se	171-22-3		10/2/2010	f Dundalk,	
Dep Dem		Aregon !	E' Krent		79	22 Wise	e Ave.	Dundalk	, Maryland	Inc. 21222
Physician /Medical		23a, Part I. Entyr the disease, of failure. Li vonly and caus	e on each line.			, .	such as cardia	ac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
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nd uted	Щ	events resulting in death) Last	Due to (or as a cons d.	sequence of):					
be exec	Medical	X UNPENDED	AMENDED 23a, PII	.27.28	Ba-f.per	ME 290	8 10/2	1/10 TT		
8760 ifficate ng phys		IF FEMALE: 23b. Was decedent pregnant in	230. II yes, outco	ome of pregn	ancy Petal of		Ectopic pre		23d. Date of delive Month	ery Day Year
tox 68760, each certificate be executed extending physician and for use as the burial - transi	sician/	past 12 months?	4 Pregnant a	at time of dea	th -	(Specify)				
b.O. Be that the de ned by the detached f	Physic	Part II. Other significant cond		th but not re	sulting in the unde	rlying cause g	iven in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
s, P.C ures that signed d be deta	å by	Cocaine and	oxycodone u	se		"		11Yes	2 No 3 Pr	obably 4 🗸 Unknown
ords aw requas been	Completed							24a. Was autop	sy prior to	autopsy findings available completion of cause of
tal Rec	S							1 Yes		
Vital Rec ysician: The l his certificate director, page	Be	25. Was case referred to medic examiner? 1 ✓ Yes 2 No	I I a a mit a li	ient 2	ER/Outpatient 3		of Death (Che		Residence 6 🗸 Oth	er: Scene
of Ving Phy	n: To	27. Manner of Death	28a. Date of Inj (Month, Day,	jury Year)	28b. Time of Injury		y at Work?	28d. Describe l	now injury occurred	. 1 1
Sion Attend r death. ector: by the f	catic	Per	estigation Fd 9/26		FD 0740 me, farm, street, fa	nrs –	es 2 No		t ingested	
Divi	Certification:		uld not be ermined (Specify)		sidence	ictory, office b	anding, etc.	or Town, S Dundalk	tate) 2801 PAg	Rural Route Number, City e Dr
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical C	29a. Certifier 1 Certifying F	Physician: To the best of n aminer:On the basis of exa and manner stated	amination an				and due to the caus	e(s) and manner as sta	ated.
E \$ E 8	Re	29b. Signature and title of certifi				29c. License			29d. Date signed (M	
	ļ	MM C		/h))	22-1	O.C.N	Л.E.		September 27,	2010
\emptyset		 Name and address of perso Russell Alexander MI 	2.40	-	,	nn Street,	Baltimore,	MD 21201		
St Regist		31. Date filed (Month, Day, Year,	32. Regist	ar's Signatur	المال					
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DHMH 17 Rev 1/2001 OCME 2006 OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Mavis Maria Anderson SEPTE 1138 23 BEK 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE AFNES POSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** Hours 1 □ M 2√2 F Months Days 29,1949 Maryland Director 61 21.7 52 5513 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Infortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If Item 10 in Maryland Examiner must be notified at agree. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 Yes 2 No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 **USA** 03 Rock Glen Road Apt.C Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. 1 □Yes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: Black þ 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Verizon 2th grade Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jerome Anderson Harriett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1909 Bulrush Court Odenton,MD 21113 /Son Edwin Whittington, III 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Greenmount Cemetery Greenmount Cemetery Baltimore,Maryland 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State :10/1/10 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman—Harris Funeral Home 21. Signature of Fuperal Service Licenses 5240 Reisterstown Rd Baltimore, Maryland 21215 arre 1 23a. Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. ck, or heart foure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fnal YR Physician Chrone Obstr. disease or condition resulting in death) / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): 68760 physician Physician/Medical attending ph Box IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) been signed by the should be detached 1 ☐Yes 2 No o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ►No 24a. Was an cate has page 2 s autopsy To the Hospital or Attending Physician: The certificate 2 No 1 ☐ Yes this certific al director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Nesidence} \) Residence \(6 \) Other (Specify) 1 Yes 2 No 1 Sinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation 129 Natural n 24 hours after death.

e Funeral Director: Af bletely filled in by the ful 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar

completely

within 24

29a. Certifier

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

ANDENSON

DHMH 17 Rev 1/2001

900

29c. License numbe

1)64307

BALTIMORE

29d. Date signed (Month, Day, Year)

MD

2010

21229

10-07228 Alfield Artis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

field Artis		State of Maryland / Department of H 1- For State Certificate of D		/lental Hy		. 2010	30871
Physici		1. Decedent's Name (First, Middle,Last)		1:	2. Date of Death		3. Time of Death
ledical Exami	ner	Alfield Artis 4a. Facility Name (if not institution, give street and number) 4b.	City, Town, or Loca	ation of Death	Month September	19, 2010 4c. County of Death	1500 hrs
_ ~			Baltimore			N/A	
Funeral				Under 24Hrs. Hours Min.	8. Date of Birth	(MM/DD/YYYY) 9. Bir	thplace (State or
Director		Usual Residence of Decedent	Bayo .	100,0	Sept	.5,193 Foreign	untry) VA
any		10a. State 10b. County 10c. City, Town or Location	7.1.1				10d. Inside City Limits
Aaryland 28a-f show 1 at once.	tor		ltimore	: 			1XX Yes 2 No
21215-0036 Muld be filed within 72 hours after death with the Maryland marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 4303 Marble Hall Road #109	Of. Zip Code 21	218	109	g. Citizen of What Cou USA	ntry?
eath with items 23 ust be no	Funeral	1 Never Married 2 Married Armed Forces? If Yes,	ecedent of Hispanions specify Cuban, Me			14. Race - Amer White, etc.	ican Indian, Black,
after de	by Fι	3 Widowed 4 Divorced If Yes, Give Year or Dates:	s 2 No sp			Specify: Bl	ack
hours "natur Exam	ted t		Usual Occupation (of working life. DO			16b. Kind of Business/	Industry
0036 vithin 72 ene. er than Medical	Completed	unknown	ruck Dr			Coca-Co	ola Co.
21215-0036 uld be filed within 72 hou Mental Hygiene. marked other than "nat c event, the Medical Esa	Be Co	17. Father's Name (First, Middle, Last) unknown		lother's Name (Inknowr		aiden Surname)	
Baltimore, MD 212 permit. Pages 1 and 2 should but Department of Health and Ment Important: If tien 27 is name! Injury or other traumatic even	T ₀	19a. Informant's Name/Relationship (Type, Print) Christine Sanford/ Niece 4318	Berger	Number or Ru Ave. I	ral Route Numb Baltimo	er, City or Town, State Ore, MD 2	, Zip Code) 1 2 0 6
re, N s 1 and f Healt If item er trau		20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Cremation 3 Removal from State 1 Crematic 3 Removal from State 1 Crematic 3 Removal from State 1 Crematic 3 Removal from State 1 Crematic 3 Removal from State 1 Crematic 3 Removal from State 1 Crematic 3 Removal from State 1 Crematic 3 Removal from State 1 Crematic 3 Removal from State 1 Crematic 3 Removal from State 1 Crematic 3 Removal from State 1 Crematic 3 Removal from State 1 Crematic 3 Removal from State 1 Crematic 3 Removal from State 1 Crematic 3 Removal from State 1 Crematic 3 Removal from State 1 Crematic 3 Removal from State 1 Crematic 3 Removal from State 1 Crematic 3 Removal from State 1 Crematic 3 Removal from State 1 Crematic 3 Removal	(Name of cemeter	ry,	1	20c. Location - City or	·
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Balt permit Depart Impor Injury			e and Address of F O Belai	CIIC		Harris Fu imore, MD	neral Home
Physician	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m failure. List only one cause on each line.					Approximate Interval Between Onset and
žxaminer		Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease	se				Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.					
	iner	if any, leading to immediate Due to (or as a consequence of):					
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68760, certificate be nding physicise se as the buric		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the				23d. Date of delivery	
K 6876 n certificate ending phy use as the	Physician/N	past 12 months? 4 Pregnant at time of death 5 Other	death 3Ed (Specify)	ctopic pregnan	су	Month E	Day Year
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of Vital Records, ag Physician: The law requint this certificate has been someral director, page 2 should	dmo				perform	ed? death?	_
Vital Rysicians T	Be	25. Was case referred to medical examiner? Hospital: Insertion 2 ER/Outsetion 3	Otho	eath (Check or			
n of Vit ling Physic After this funeral dire	은	1 V Yes 2 No 1 Impatient 2 Errodipatient 3 27. Manner of Death 28a. Date of Injury 28b. Time of Injury	_ box	- Indiang		esidence 6 🗹 Other w injury occurred	Scene
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Division tal or Attendi rs after death. al Director: #	Certification:	3 Suicide 6 Could not be determined (Specific)	actory, office buildin	ng, etc. 2	8f. Location (Str or Town, Sta		ral Route Number, City
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A		4 Homicide 29a. Certifier (Check only one) 29 Medical Examiner: On the basis of examination and/or investigation,					
To the within To the comp	Medical	and manner stated. 29b. Signature and title of certifier	29c. License nun			29d. Date signed (Mor	
		Grusot Frethall wir	O.C.M.E.			September 20, 2	010
4		30. Name and address of person who completed cause of death (Item 23a) Pomple E. Southell M.D. Assistant Modified Examines 111 P.	lann Ctua - 1 D	altimar. Ar	21224		
` ` `	ate	31 Date filed (Month Day Yord) 32 Plaistrat's Signature 4	enn Street, Ba	aitimore, ME	21201		
ى Regist		OCT 0 4 2010	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Charles Holton Acker Jr. 2010 3:01 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville 8. Date of Birth
(Month, Day, Year)
Jan. 3, 1928 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ E Florida Director 263-20-8370 82 Jan. Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director MD Carroll 1 Yes 2X No New Windsor 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1624 Old New Windsor Rd. 21776 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ ò 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify. Specify: 3 ☒ Widowed 4 ☐ Divorced Completed White Year or Dates. 1946-50 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than * Elementary/Seconday (0-12) 12 College (1-4 or 5+) Minister Methodist church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental H marked o ၉ should be Charles H. Acker Sr. Gladys Irene McCraven 19a. Informant's Name/Relationship (Type, Print) and is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Page 1 and 2 Charles H. Acker III - son 8831 Mourning Dove Ct., Gaithersburg, MD 20879 t of Healt : If item? y or othe Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a, Method of Disposition 1 Durial 2 Cremation 3 Removal from State Department Important: If any injury or 4 Donation 5 Other (Specify) All County Cremation: 10/6/2010 Sykesville, MD . Signatule of Funeral Service Licenses 22. Name and Address of Facility Hartzler Funeral Home 310 Church St., New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Acute cardiac arrhythmia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Chronic respiratory failure Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, Cause (Disease or linjury that initiated events resulting in death) Last Hypertension Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Anoxic encephalopathy Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Atrial fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy Osteomyelitis 1 ☐ Yes 2 🔀 No 2 No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 X No Other: ၉ 1 Yes 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending injury 1 Yes 2 No after death Director: / Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral D Medical 29a. Certifie 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature

State Registrar Center Dr., Rockville, MD 20850

9901 Medical

32. Registrar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nicole Evancich MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MA 01:80 September Orio 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center N/A Baltimore Birthplace (State or Foreign Country) 6. Sex If Under 24 Hrs. 8 Date of Birth 7. Age (In vrs. last birthday) Funeral 1 □ M 2 🔏 F (Month, Day, Year) 220-64-5928 Director 55 Marvland Usual Residence of Decedent 10b. County 10a State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified MD N/A Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2223 Eutaw Place Apt. 1 21217 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ntary/Seconday_(0-12) College (1-4 or 5+) Elementary/Seconday (U-12th Grade Care Provider Arc of Baltimore Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sam K. Davis Clara M. Miller 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charisse Harris-Johnson 817 N. Aisquith St. Baltimore, MD 21202 item 2 Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. emetery, crematory or other place)
t. Zion Cemetery 9/25/10 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman—Harris Funeral Home 4210 Belair Road Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Intracerebral Hemorrhage disease or condition Medical resulting in death) Examiner years pertension Sequentially list conditions Examine If any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No ☐ Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 MNo Other: ျာ 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending work? after death. 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined within 24 hours a To the Funeral D Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

Registrar DHMH 17 Rev 7/2009

State

Qo

Anjail Sharrief

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ND

4940

RES-000

Eastern Avenue BALTIMORE

September 16 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G908 10/12/10 Jh State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 29/2010 9:25 A M Virginia Bidinger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Carroll Hospital Center Westminster Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 6. Sex Age (In yrs. last birthday) 1 🗆 M 2 🕱 F Month Pay / 1926 MD Director 83 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 X No Carroll Woodbine 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21797 USA 7258 John Pickett Rd. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 24 No Specify: 3 Divorced 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Her Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur Levi Haines Evelyn Bair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl Bidinger/Husband 7258 John Pickett Rd., Woodbine, MD 21797 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 10/5/2010 Woodbine, MD 4 Donation 5 Other (Specify) Pleasant Ridge Cem. 21. Signature of Funeral Service Licer Burrierd Otte En Funeral Home & Crematory, 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition CDDMedical resulting in death) Due to (or as a consequence of): Examiner JU WIL Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Chronic Depression. 1 Yes 2 No 3 Probably 4 Unknown Chroni Cysters 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician To the best of my knowledge, dean own Medical Examiner: On the basis of examination and/or investigation 29a. Certifier fied at the time, date and place, and due to the cause(s) and manner as stated. ation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner. In the best of my kg death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 1737949

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year (1 Acmbo (29. 7010 4a. Facility Name (If not institution, give street and nu 4b City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 XXM 2 □ F 218-40-9387 Yrs. 67 11/12/1942 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Towson 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 624 Sussex Road 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 1 Never Married 2 X Married 1 ☐ Yes 2XX No Specify Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 4 MArket Research Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin Earl Boughter Dorothea Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Patricia Scott Boughter 624 Sussex Road Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State □ Burial 💢 🐧 Cremation 3 🗆 Removal from State GreenMount Crematory ☐ Donation 5 ☐ Other (Specify) 10/01/2010 Baltimore, Maryland ignature of Funeral Ser 22. Name and Address of Facility M(TCHELL- WILDLESTO F.H 2/2/2 BOUTI MOZE, MD 4500 XURK 20 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 3a. Part 1. Enter the disease complication shock, or heart failure. Immediate Cause (Final embolism ulmonary disease or condition resulting in death) Due to (or as a consequence of): una cancer Sequentially list conditions, Dise to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal dea Pregnant at time of death 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No 9 Unknown 9 Unknown

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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Examiner

IF FEMALE:

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

the burial-transi Physician/Medical Completed Be Certification: To Medical

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To the Hospital or Attending Physician: The law requires that the death certificate be executed Director: A thin 24 hours after the Funeral Direct mpletely filled in b within 2

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complex

Division of Vital Records, P.O. Box 68760,

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		ontibuting to death but not re		1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown				
4							24a. Was an autopsy performed? 1 \(\text{Yes} \) 2 \(\text{No} \)	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred					26. Place of De	ath (C	heck only one)	
examiner? 1 ☐ Yes 2 🔀 No		Hospital: 1 Inpatient 2	Home	e 5 Residence 6 Other (Specify)				
27. Manner of Death 1 Natural 2 Accident	5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28	3c. Injury at Work? 1 ☐ Yes 2 ☐ No	280	d. Describe how injury	occurred
3 Suicide 4 Homicide	6 Could not be determined	28e. Place of injury - At h building, etc. (Speci	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier 11 (check only one) 2	Certifying Phy Medical Exam	ysician: To the best of my kniner: On the basis of examin	owledge, death o ation and/or inve	occurred a stigation,	at the time, date and place in my opinion, death occ	e, and	d due to the cause(s) at the time, date and	and manner as stated. place, and due to the cause(s)

29c. License number

MD

RES-000 September 29, 2010

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12015

29b. Signature and title of certifier

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 22 Month Physician/ PEPTEMBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE LCHRIST 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 - M 2 - F Months Hours Min. Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director MD Baltimore Nottingham 1 Tes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4300 Cardwell Avenue #114 21236 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 X Widowed 4 □ Divorced "natural" Completed and Mental Hygiene.

7 is marked other than "natur raumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) year Elementary/Seconday (0-12) Administrative Asst. Hospital Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, ionce. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Katie Walton Robert Lee 19a. Informant's Name/Relationship (Type, Print)
Ronald Carr/ Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2405 Fleetwood Ave. Baltimore, MD 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 9/29/1b Quantico Nat'l. Cem. TRiangle, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Chatman-Harris Funeral lla ar 4210 Belair RoaD Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ONGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any localing to immediate cause. Enter Underlying Cause (Cisease or iinjury that initiated events Examine Due to for as a consequence of 108 attending physician and for use as the burial-transii resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month 1 Yes 2 g Unknown ned by the a e detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signe rector, page 2 should be CORENARY ARTERY DISENSE Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 2 🗹 No 2 🗌 No ☐ Yes 1 Tyes Be (25. Was case referred to medical examiner? Division of Vital funeral director, 26. Place of Death (Check only one) Hospital 2 No Other: ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending s after death.

I Director: Aff
d in by the fur 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after des To the Funeral Director completed filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar 29b. Signature and title of certifie

31. Date filed (Mo

gistrar's Signature

nd address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D46360 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dav Paula Month R. Crepeau 1:00 a M 09/30/2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Stella Maris Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Germany Stuttgart. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 1 🗆 M 2 🔀 F Days Hours Min. (Month, Day, Year) 02/01/1927 053-28-9088 83 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Elkridge 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5764 Augustine Ave. 21075 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 ☐ Yes **XX** No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3XXWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Self-employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Karl August Geiger Elisabeta Barbara nee Imhoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Conrad / Daughter 5764 Augustine Ave., Elkridge, MD 21075 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington Nat'l Cem. 10/28/2010 Arlington, VA 22. Name and Address of Facility
Bailey Funeral Home and Cremation Service, PA
4023 Annapolis Rd., Halethorpe, MD 21227 21. Signature of Funeral Service Licenses male & M0145 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ END STAGE RENAL DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence on attending physician and for use as the burial-transit Due to (or as a consequence of): The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an certificate has autopsy prior to completion of cause of death? 2 X No 1 Yes 2 No Yes the Hospital or Attending Physician: he Funeral Director: After this certific the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State OCT 0 4 2010 Registrar

DHMH 17 Rev 7/2009

SEPTEMBER

CREPEAU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		. 101	partment of Health and I	Mental Hygiene	
	,	1 - State Registrar	ertificate of Death	Reg. No.	0 20079
Physicia	ın/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death Year
Medic		Clarence L Detzel			MAD 400 01°C
Examin	er	4a. Facility Name (if not institution, give street and number) John's Hopkins Bayyiew Medical Center	4b. City, Town, or Location of Death	4c. County o	f Death
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth	Birthplace (State or Foreign
Director		217-24-6500 1 XM 2 F 81 Yrs	Months Days Hours Min	(Month, Day, Year) 5-30-1929	Country) MD
- MO -	١.	Usual Residence of Decedent			
yland -f sh	턍	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
e Mau r 28a notifi	ie	MD Baltimore Dundal	. K 10f. Zip Code	Lab and dist	1X Yes 2 □ No
vith th	la I	1606 Gray Place	21222	10g. Citizen of Wh	nat Country?
ems ems	Funeral Director		Was Decedent of Hispanic Origin? (Sp		- American Indian,
ter de mine	by	1 ☐ Never Married 2 🔀 Married	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) Black,	, White, etc.
2 hours after "natural", o	Completed	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates. Korean	1 ☐ Yes 2 █ X No Specify:	Specify:	White
72 hc	nple	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work b. DO NOT use retired)	sing 16b. Kind of Bus	iness Industry
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shoul and is m		1	ailing Address (Street and Number or Rui		
and 2 Health			06 Gray Place,		
ge 1s in fift or of		1 Rurial 2 Cremation 3 Removal from State cemetery,	sposition (Name of crematory or other place)	ı	City or Town, State
partilliore, indexivation Z.I.Z.13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Specify) Atlant 21. Signature of Funeral Service Licentee	cic Crematory 9-		
Departing Departing any income.		De Harry	2134 Willow Spr	adley-Ashton	Funeral Home
		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.		-	Approximate
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The la	Completed by			performed? de	ath?
Physician: Th Physician: Th this certificate ral director, pa	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec	k only one)	
Physic this c	-T	1 ☐ Yes 2 KNo Prospital: 1 ☐ Inpatient 2 K ER/Outpa 27. Manner of Death 28a. Date of injury 28b. Tim		ome 5 Residence 6 Other	
ding 1 After funer	cate	1 Natural 5 ☐ Pending (Month, Day, Year) injur		28d. Describe how injury occurred	
Atten r deal	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,		28f. Location (Street and Number	or Rural Route Number,
s affer		building, etc. (Specify)	ļ	City or Town, State)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier (Check 2 Medical Examiner: On the bast of my knowledge, dea	th occured at the time, date and place, a	nd due to the cause(s) and manner	as stated.
thin 2, the F the F	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier	e, death occurred at the time, date and pla	ce, and due to the cause(s) and mann	ner as stated.
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,		30. Name and address of person who completed cause of death (Item 23a) (Typ	Print) P0028884	deptemb	en LT) LUIV
6			has Hopking Bar	view Medical	1 Center
Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1		
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			Registrar 1. Decedent's Name (First, Middle, I	Last)			or beauty	2. Date of Dea	ath	3. Time of Death
2	Physicia Medic	al	Christian		nkenber	9		Month 9	Day 29 Year	10:30 PM
0	Examin	er	4a. Facility Name (if not institution, g	vell Circle	(own, or Locatio lumbia	n of Death	4c. County of Dea	4
-	Funeral Director		5. Social Security Number 213-81-0862	. Sex 1 DM 2 □ F	e (In yrs. last birth	nday) If Under Months	1 Year If Und Days Hours	er 24 Hrs. 8. Date of Birl Min. (Month, Da	h 9. Bi (, Year) Co 1/2007	rthplace (State or Foreign ountry) MD
رة -	and show	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location		,		10d. Inside City Limits
2	e Maryla r 28a-f s notified	Direct	MD 10e. Street and Number	Howard		105 7:-		lumbia		1 🗆 Yes 2 🗹 No
200	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral Director	9104 Bronze Bell Cit	cle	/	10f. Zip		1045	10g. Citizen of What C	S.A.
Ž.	r death or item niner n		11. Marital Status 1 ☑ Never Married 2 ☐ Marrie	12. Was Decedent I Armed Forces? d 1 \(\sum \) Yes 2 \(\sum \)	Eyer in U.S.	13. Was Decede If Yes, specif	ent of Hispanic C fy Cuban, Mexic	Origin? (Specify Yes or No- can, Puerto Rican, etc.)	14. Race - Am Black, Whi	
203	urs afte ural", c il Exam	Completed by	3 Wildowed 4 Divorced	If Yes, Give Year or Dates.	No	1 ☐ Yes 2	No Speci	fy:	Specify:	hite
子5-6	72 hou n "natu fedica	nplet	15. Decedent' (Specify only highest	grade completed)	1.7	Decedent's Usual (Give kind of work life. DO NOT use i	done during mo	ost of working	16b. Kind of Business	Industry
212			Elementary/Seconday (0-12)	College (1-4 or 5	ō+)	ille. DO NOT use i	Child			hild
2h f(Maryland		To Be	17. Father's Name (First, Middle, Las	t) Christian M Fra	nkenberg		18. Mo	ther's Name (First, Middle,	Maiden Surname) Mi Jung Pak	
Ry. Man	2 shouth and the and the and the traum		19a. Informant's Name/Relationship Deborah Frankenbe					ber or Rural Route Number cle Columbia, MD		ip Code)
ゴンチ altimore	Page 1 and nent of Heal ant: If item 3 ıry or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from State	cemeter	Disposition (Name y, crematory or oth intic Cremator	her place)	Date Oct 02, 2010	20c. Location - City o	r Town, State Burnie, MD
D.T. Balti	permit, Page Department of Important; If any injury or once.		21. Signature of Funeral Service Do	ensee Pac	MO12912	22. Name and 38	Address of Fac ack Funeral 71 Old Colu	Home, P.A. mbia Pike Ellicott (City, MD 21043	
			23a. Part Ent r the dise se, or co shock, or heart failure. List onl	omplications that caus y one cause on each line	e death. Do no					Approximate Interval Between
6	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)		euroblas					Onset and Death
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Bo)	requires that the death certificate been signed by the attending physhould be detached for use as the	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant a 9 Unknown	t time of death	5 Other (spe	cify)		Month	Day Year
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Division of Vital Records, P.O. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	Certificate:	3 Suicide 6 Could no 4 Homicide determine	t be	ury - At home, fari c. (Specify)	m, street, factory,	office	28f. Location (S City or Tow	treet and Number or Run, State)	ıral Route Number,
	Hospita 24 hours Funeral leted fille	Medical	(Check 2 Medical Exa	miner: On the basis of e	xamination and/or	investigation, in m	y opinion, death	d place, and due to the cau occurred at the time, date a ate and place, and due to the	nd place, and due to the	cause(s) and manner stated.
	To the within comp		29b. Signature and title of certifier)	D, MHS	29c. l	License number		29d. Date signed (Mont	
	ā	-	30. Name and address of person wh						1,700	110
	A		600 N. Wa	o completed cause of different St. CM	2.C800 B	attimore,	MU de	xo/ Heat	ner Jym	01/2
	Stat	e	B1. DOCT (10"4 2010)	Annu 32. Registr	SOUTHER					

10:30pm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo O. L.O.

			1 - For State Registrar	State of Marylar		tificate of L			eg. No.	30881
	Physic	ion	1. Decedent's Name (First, Middle, La	st)				Date of Deal Month		3. Time of Death
	/Medi	cal	JOANNE 4a. Facility Name (If not institution, giv.	o otroot and number)		JONE 4b. City, Town, or		SEPTEMBI	ER 29 2010	14:26 PM
	Exami	ner	The Johns Hopkins H			Baltimore			4c. County of Dea	ith
	Funeral	г	5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bit	thplace (State or Foreign
	Director		5/0-00-241/	M 2 X F 60	Yrs.	Months Days	Hours Min.	(Month, Day, 6-8-19		C
	land ow t		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	a-f sh	ctor	MD P.G.	qqU	er Mar	lboro				1√2 Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip-Code		1	0g. Citizen of What Co	ountry?
	s 23a		1005 Butterwort			20774			S.A.	
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	1	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: a C	e, etc.
21215-0036	thin 72 h e. an "natu Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4 or 5+)	(Give i	lent's Usual Occupa kind of work done of OO NOT use retired	during most of work)	king	16b. Kind of Business	Industry
121	led wi lygien her th it, the		17. Father's Name (First, Middle, Last)	12	Docur	ment Pro				ermanente
Maryland	ould be fi Mental H arked otl atic even	To Be	Thomas Blai				Katie	Spe	Maiden Surname) NCE	
, Mar	and 2 sho saith and 27 is m		19a. Informant's Name/Relationship (Willie J. Jones	ype. Print) 5/Husband	19b. Mailin	g Address (Street & Butterv	and Number or Ru Vorth Li	n. Uppe	r, City or Town, State, in Marlbo:	zip Code) ro, MD
Baltimore,	Pages 1.		20a. Method of Disposition 1	Removal from State	Place of Disponentery, cremetery, cremetery	sition (Name of place of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control	eterv 1	ľ	20c. Location - City or Suitland	
alti	permit. Departm Importa any inju once.		21. Signature of Funeral Service Licens		0 22	Name and Addres	s of FacilityRor	nald Ta	ylor II	FH
8	9 9 E E P		(pando)	real mal	0 10)583 Mid	ldleport	Ln. W	hite Pla:	ins, MD
	Physician		23a. Rath. Enter the disease, or com- shock, or heart failure. List only of Immediate Cause (Final	ine cause on each line.				or respiratory arr	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a conseq	uence of):	loid Leu	cemia			
	Lammer	ē	Sequentially list conditions,	b						
<i>y.</i>	ted insit	Examiner	cause. Enter Underlying Cause (Disease or injury	Jule to (or as a conseq	tier de dt)".					
1	rificate be executed g physician and as the burial-transit		that initiated events resulting in death) Last	Due to (or as a conseq	uence of):	<u> </u>				
68760,	ate be nysicia the bu	Medical		d						
	T 2 1		IF FEMALE:	23c. If yes, outcome of pregna	ancy					
Вох	attend d for u	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta 4 Pregnant at time of d	l death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
P. O.	t the c by the	hys	9 Unknown	9 🗌 Unknown						
Records, F	The law requires that the death cer te has been signed by the attendin page 2 should be detached for use	þ	Part II. Other significant conditions or	ontributing to death but not res	sulting in the ur	nderlying cause giv	en in Part I.	23e. Did tob	oacco use contribute to s 2 □ No 3 Pr	o the cause of death? obably 4 \(\subseteq \text{Unknown} \)
9 0 0	aw rec is beer 2 sho	Completed						24a. Was an		utopsy findings available completion of cause of
<u>~</u>	r age	Con						perform	ned? death?	·
Ĭ Ĭ	yslcian: The l s certificate ha director, page	m	25. Was case referred to medical examiner?	Hospital:		2 DOA Other	26. Place of Death			
ō	Jing Phys n. After this of funeral di	은	1 Yes 2 No 27. Magner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	3 DOA 28c. Injury	4 U Nursing Ho	me 5 LResider 28d. Describe ho	nce 6 Other (Spec	cify)
ion	Attending Physician: 3r death. ector; After this certific. by the funeral director,	atio	Natural 5 Pending 2 Accident investigation		Injury	M 1 □ Y	es 2 🗆 No		, ,	
Division of Vital	al or Atte s after de l Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, stree	et, factory, office		28f. Location (Str City or Town,	reet and Number or Ri State)	ural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dirt completely filled in		29a. Certifier (check only one) 2 Medical Exam	rsician: To the best of my knowiner: On the basis of examinat and manner stated.	wledge, death tion and/or inve	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the carred at the time, do	ause(s) and manner as ate and place, and du	s stated. e to the cause(s)
1	To the comp	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Montl	h, Day, Year)
	ر ا) No			RES	5-000	9	EPIEMBER :	29 2010
	C		30. Name and address of person who		n 23a) (Type, F	rint)	600			
	Sta	e	31. Date_filed_(Month_Day_Year)	32. Registraris Signat	e j		1 000	AOITH WOR	e Si, Bailimo	ore, MD, 21287
	Registra	ar	OCT 0 4 2010 Z	Keenas a. a	arke					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician eune (0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Lorien Frankford Nursing Home Baltimore N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 219-23-0818 1 □XM 2 □ F 28,1989 Maryland March Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State r 28a-f show notified at N/A Baltimore 1X Yes 2 □ No MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 21225 USA 4131 Hyden Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or items the Medical Examiner ma 11 Marital Status Black, White, etc. 1 XNever Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Black <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Univ. of MD 12th Grade College (1-4or 5+) Medical Records Clerk permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 Is marked other th any Injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Annette Matthews Larry H. Keane, 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 4921 Goodnow Rd. Apt. L Baltimore, MD Tyesha Keane/ Sister Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Oaklawn Cemetery 10/1/10 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 4210 Belair Road Baltimore, MD 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Van o Phoryngium a
Due to (or as a consequence of): ut cower if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Pan II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by epvein thrombases 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Seizure 24a. Was an autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No 27. Manner of Peath Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Physician /Medical Examiner burial-trar Vital Records, P.O. Box 68760, page 2 should Division or after death.

I Director: Aid in by the fu

To the Hospital or Attending Physiclan: within 24 hours after dea To the Funeral Directo completely filled in by th

show

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite

I Hygiene.

Maryland 21215-0036

3altimore,

State Registrar 29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

K087625

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \$21. N: Ecutau St.

Balkmore, MD 212

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifie

32. Regist ar's Signature

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 30883 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Edith October 2010 12:29 AM Mae Koerner Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner 1012 North Avenue Essex Baltimore 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Days Hours Min Maryland **Director** 219-30-5153 Usual Residence of Decedent show . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.

Tant If flew 22, is marked of other than "natural", or items 23a or 28a-f sho into or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Baltimore Maryland Essex 10f. Zip Code Street and Number 10g. Citizen of What Country? Funeral 1012 North Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14, Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 Specify: White If Yes, Give 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County h and Mental Hygien 7 is marked other th traumatic event, th 8 <u>Cafeteria Worker</u> School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph McCall Elizabeth Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Linda Susan Ford (Daughter)</u> <u>2228 Coralthorn Road Middle River, MD 21220</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard. Middle River, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Hom 1407 Old Eastern Avenue Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death METASTATIC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a d be detached f ned 1 1 L Yes 2 -9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>&</u> 1 Yes 2 No 3 Probably 4 Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy performed? Yes 2 AN 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Matural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After t 5 \square Pending injury 1 Tes 2 No Accident Investigation within 24 hours after deatl

To the Funeral Director: 6 \square Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 [__ only one)

State Registrar 29b. Signature and title of certifier

mi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

pbell 32. Registrar's Sig 29c. License number

1061480

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per G908 10/22/10 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 29, 2010 9:20A CAROL NEWMAN KELLY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson The Maples of Towson If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1 🗆 M 2 🕠 F 1072471938 Connecticut Director 71 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 🗆 Yes 2 😿 No Marvland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7925 York Road 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes : Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Private School Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Helen McGranor Arthur Newman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark L Kelly Son 2425 CLifftops Avenue Monteagle Tennesse 37356 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 🗆 Burial 2 ሺ Cremation 3 🗔 Removal from State GreenMount Crematory 109/30/2010 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. ignature of Funeral So 6500 York Road Baltimore, Maryland 21212 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition) Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this confidence. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year 1 ☐ Yes 2 p 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗷 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 A Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00061485 A2200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bushra Al-Azzawi 9109 Franklin Square Dr Balto MD 21237 31. Date filed (Month, Day, Year) State OCT 0 4 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bonnie V. Leimbach Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Good Samaritan Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 232-26-3226 1 M 2 X F Hours 89 1071071920 West Virginia Director Yrs Usual Residence of Decedent 28a-f sho 10b. County 10a. State the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Timonium 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 104 Belfast Road U.S.A. 21093 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify. 'natural", Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4 or 5+) Elementary/Seconday (0-12) 12 Inspector Can Company and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Should be Department of Health and Menta Important: If item 27 is marked any injury or other traumathments. 2 Minor Van de Vander Nora Lambert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Fitzpatrick/Grandson Fleetwood Ave. Baltimore, Maryland 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lorraine Park 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remoyal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment 10/9/2010 Baltimore, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ oncestive disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** MONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Month Year Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 2 No Hospital or Attending Physician; ¹ 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 Inpatient 2 DER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Matural 5 Pending injury 2 Accident
3 Suis 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 1, 2010 H2068954 790

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

wankaun

30. Name and address of person who completed ause of death (Item 23a) (Type, Print)

5001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ Month Elizabeth Caughy M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 💢 F $\text{Mav}^{\text{(Month)}}28^{\text{ay}}$ Maryland Director 215-16-2070 88 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27:3 marked of other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct 1 🗌 Yes 2 💢 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 U.S.A. 821 Fairway Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 🗓 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Rug Cleaner Billing Administration 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Marie Charlotte Collins John Hamilton Caughy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 821 Fairway Drive Towson, Maryland Kathleen Sergi (daughter) 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Veterans Cam. 10-6-10 Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility}
Mitchell-Wiedefeld Funeral Home,
6500 York Road Baltimore, Mary lome, Inc. Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or iinjury Due to (or as a consequence of): Examir physician and the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death signed by the a 9 Unknown a | Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an certificate has blirector, page 2 s autopsy death? 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 🛣 No ျ 1 🗌 Yes 1 Malinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 1 Natural
2 Acciden 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred I Director: After to a in by the funeral injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral D To the Hospital Medical 29a. Certifier Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ١0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 30887 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 0 9 2010 Leiser 3:05 AM Sieglinde Luise Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Harford Memorial Hospital Havre de Grace Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Davs Hours Director 218-72-3435 69 02/08/1941 Germany Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c, City, Town or Location 10d Inside City Limits Director MD Harford Aberdeen 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be I Funeral 901 Barnett Lane, Apt. 402 21001 Germany 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 N Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) At Home Homemaker 8 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည of Health and Menta fitem 27 is marked rother traumatic e Georg Jakob Heid Luise Weinlein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marina Wright (Daughter) 824 Matthews Ave, Aberdeen, MD 21001 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) Ferris & Co. 09/28/2010 21. Signatur Funeral Service Lic 22. Name and Address of Facility
Tarring-Cargo Funeral Home
333 S. Parke St. Aberdeen, Funeral Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MONARY Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (of as a consequence or) Exami -transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

Secondariat time of death

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the a Id be detached for 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Sieg Records, 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Within 24 yours after death.

To the Funeral Director, After this certificate has been si
To the Funeral Director, has funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ည 1 Inpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certify 29c. License number 29d. Date signed (Month, Day, Year) 2010

DHMH 17 Rev 7/2009

State Registrar

09/26/

istrar's Signature

21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 30888 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Month 2:50 AM Margaret Lowman 09 29 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Harford Havre de Grace tf Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 XF 93 215-28-8313 Virgínia Director 11/16/1916 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits show the Medical Examiner must be notified at Yes 2 □ No Directo Maryland Harford Aberdeen 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5 724 Custis St. 21001 USA 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No tf Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify:White 1 ☐ Yes 2 XNo Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At home 3 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other treumatic event, ODCs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roby Richardson Audie Eller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dewey Lowman / Son 724 Custis St, Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MBurial 2 Cremation 3 Removal from State 4 ☐ Donation _ 5 ☐ Other (Specify) Bel Air Mem.Gdns. 10/4/2010 Bel Air Tarring-Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 21. Signature it Fungrat Survice Lious see ronle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** THEUMONIA /Medical Due to (or as a consequence of): Examiner Heart FAILURE Congestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as so onsequence of). Examiner use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? After this certificate 1 ☐ Yes 2 ☑ No 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death Check only one examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how intury occurred **≯** Maturai 5 Pending death. 1 TYes 2 No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) in by 1 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital pellij Contributing Physician: To the best of my knowledge, death consisted at the time, date and place, and due to the eases(e) and manner as state; 29a Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D00 69 118 501 S. UNION AVE HAVRE de GRACE, MD 21078 Signatures. parks 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

LhAli D 31. Date filed (Month)

-DUMAN Margare

pistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month 41.038 arry ptembec 1010 . Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death N/A balk to so ta 1+ 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) (In yrs, last birthday) Months Days Hours Min. 219-52-9885 **1**√ M 2□ F 61 Oct.12,1948 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits N/A 1X Yes 2 □ No Baltimore 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 1804 Guilford Avenue 1st Flr. 21202 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12th Grade College (1-4or 5+) Laborer Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Frazier Lucille Marshall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane White/ Sister Stonewood Road Baltimore, MD 21239 20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Greenmount Cemetery 9/28/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie 22. Name and Address of Facility Chatman-Harris Funeral Home KKE 4210 Belair Road Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1100 disease or condition resulting in death) Due to (or as/a) consequence.of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) ulat initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ZULYes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🗡 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 XER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

show

death v

72 hours after

s 1 and 2 should be filed wi f Health and Mental Hygier Item 27 is marked other th

permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Experimental be notified at

Examine

burial-transit and attending physician for use as the buria the as signed by the a ld be detached f has been si je 2 shouîd t page certificate director,

law requires that the death certificate be execute

The

Hospital or Attending

death.

this

Box 68760.

P.0.

Division of Vital Records,

Physician/Medical à Completed Be Certification: To After th funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

examiner?

29a. Certifier

(Check only

Medical

State Registrar

Yes 2 □ No 27. Mauner of Death

1 Natural 5 Pending Accident investigation 6 ☐ Could not be 3 Suicide 4 ☐ Homicide

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number FF11418

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BABARINOE FADIREPO MD, 2323 ORLEANS ST Baltmores MD 21224

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month eporcic CTUBE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CKERS God ALTIMORE BALTIMORE Birthplace (State or Foreign Country)
 New York 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1 🛛 M 2 🗆 F Months Days Min Director 051-10-8736 98 Usual Residence of Decedent fshow 10a. State 10b, County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director · 28a-f Md. Howard Sykesville 1 Tes 2 X No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 14050 Forsythe Rd. 21784 USA or items filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced SpecifyWhite Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Engineer City of Baltimore Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Hanna McLaughlin Mary Angelia Orr and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a Mr. Thomas G. McLaughlin/ Son 14050 Forsythe Rd. Sykesville, Md. 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Co. 10-4-10 4 ☐ Donation 5 ☐ Other (Specify) Towson, Md. 22. Name and Address of Facility
Owson Funeral Home, 21. Signature of Funeral Service Licenses York Rd. Towson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Omet and Death Physician/ disease or condition resulting in death) NA Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examin law requires that the death certificate be executed ere BROVASO physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Box 68760 as 1 attending property for use as IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent preg*n*ant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 2 No the ; Unknown 9 Unknown P.O. I ed by t detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas page 2 RILLATION performed' Hospital or Attending Physician: The certificate ATRIA 2 No 1 Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Deat .- Check only one) examiner? Hospital 2 No Other: ျ 4 Nursing Home 5 Residence 6 Other (Specify) this 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural iniury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, Cify or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Day, Year)

0 4 2010

DHMH 17 Rev 7/2009

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		-	for State Registrar			ertificate of			1. No 2 0 1 0	30891
Diversi		,	1. Decedent's Name (First, Middle,	Last)				2. Date of Death		3. Time of Death
Physi Me	cıar		Howard Alber	t Maccubbi	.n			Septembe	Day Year 23, 20	10 8:25am ^M
Exam	nine	er	4a. Facility Name (if not institution,	give street and number)		4b. City, Town, o	r Location of Death		4c. County of De	
- فأم		4	5 Brown Cone Ga 5. Social Security Number	rth		Notting	nam		Baltimore	e County
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fire Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		Completed by Funeral Director	11. Marital Status1 ☐ Never Married 2 ☐ Marrie3 ✗ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 M Yes If Yes, Give Year or Dates.	Ever in U.S. 13 No. 10/1/1945 11/17/1946	. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	nerican Indian, ite, etc. White
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shoul and i			19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ling Address (Street	and Number or Run	al Route Number, Ci	ty or Town, State, Z	Zip Code)
nd 2 ealth m 27			Janice L. Reil	ly DTR	. 5 1	Brown Cone	e Garth 1	Nottingha	m, Md. 21	1236
Page 1 a tment of H tant: If ite jury or oth			20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 4 ☐ Conation 5 ☐ Other (Sp.		Loudo	ematory or other place n Park	9-27	-2010 C	c.Location - City cationsvil]	le, Md.
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thin 24 hour the Funers of the Funers	Mo					L ZYC LICENSE	number	I 29d.	Date signed (Mont	
within 24 hour To the Funers completed fille	M	2	29b. Signature and title of certifier	MD		DG77	-83	I .	3912412	
within 24 hours after death. To the Funeral Director. After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached.	Mo	2		o completed cause of de	ath (Item 23a) (Type,	DG77		I .	912412	2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State Registrar	riease			id / Dep		Health and Death	-		2010	30892
	Physicia		1. Decedent's Name	e (First, Middle, La seph Mad						2. Date of De Month Septem		29 , 2010	3. Time of Death
	Medic Examin		4a. Facility Name (if		e street and number)			4b. City, Town,	or Location of Deat		4c.	County of Death	eorge
	Funeral Director		5. Social Security N 213-56-1	umber 6.		ge (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Bi (Month, Da March	rth av, Year) 15,1	9. Birth	place (State or Foreign htry) MD
		tor	Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or L	ocation					10d. Inside City Limits
	the Mary or 28a-f	I Director	MD 10e. Street and Nur	Prince	George	L	aurel	10f. Zip Code			10g. Cit	tizen of What Coul	1 Yes 2 X No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	<u> </u>	11. Marital Status	rk Hall_	12. Was Decedent Armed Forces?	?	S. 13	20707 Was Decedent of If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No o Rican, etc.)	USA -	14. Race - Americ Black, White,	
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Baltimore, Maryland 21215-0036	Page 1 and lent of Hea nt: If item ry or othe		20a. Method of Disp	position	Removal from State	20b. F	Place of Disp cemetery, cre	osition (Name of matory or other place)	ace) Octo	Date ber 4,	20c. Lo	ocation - City or To	own, State
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ρ_{AU} Division of Vital	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page:	Certificate: To	27. Manner of Death 1 Natural 2 Accident	h 5 Pending Investigation	28a. Date of inj (Month, Da	ury	28b. Time injury	wo	ıry at	28d. Describe		6 ☐ Othe <u>r (Specif)</u> y occurred	<i></i>
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	CI		30. Name and addr	ess aperson who	completed/cause of	death (Item	Cata	Print) Ave	Be	eltimo	ve	MD	21229

State Registrar 10-07500 Ardrev Murphy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

durey Marphy		·	icate of Death		201(3089		
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	Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XX No 3 Widowed 4 Divorced If Yes, Give Year	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto Yes 2 X No specify:		14. Race - Ameri White, etc. Specify: Bla	can Indian, Black,		
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Baltimore, permit. Pages 1 as Department of He Important: If ite injury or other tr		Artifical Cemator 1 0/05/2010 Odenton MD 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses M01452 Wartifical Cemator Veneral Service Licenses M01452 22. Name and Address of Facility Wile H 08 N. Citim St. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart Approximate Interval						
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To the Hosp within 24 ho To the Func completely f	Medical C	29a. Certifier (Check only one) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
F 3 F 3	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon			
		30 Name and address of person who completed across of death //	O.C.M.E.		September 30, 20	UTU		
		30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
St		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Sarke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NERTON BEVERLY M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE RANDAIZSTOWN NONTHWEST 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9, Birthplace (State or Foreign **Funeral** 1 □ M 2 🖺 F Months Davs Hours Oct. 23, 1961 Mary land **Director** 218-80-9320 Usual Residence of Decedent 28a-f show 10b. County 10c. City. Town or Location with the Maryland 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No Maryland | Baltimore Windsor Mill 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 104 Green Pine Court Apt. 3B 21244 within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: If Yes, Give Year or Dates SpecifyBlack other than "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16b. Kind of Business Industry Spring Grove 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State Hospital Administrator Be any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o ပ္ permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked Herbert H. Norton, Sr. Beverly Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Norton/Mother 104 Green Pine Ct. Apt. 3B Windsor Mill.MD 21244 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify Emtombment 10/6/2010 Woodlawn Cemetery Windsor Mill,MD 22. Name and Address of Facility Chatman-Harris Funeral Home Signature of Funeral Service License 5240 Reisterstown Road Baltimore, MD 21215 Varno 23a. Part Inter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart force. List only one cause on each line. Approximate Interval Between Onset and Death ANTERIOSCLERDYIL (ARO) OVASLUZAR Physician/ disease or condition resulting in death) Medical Medical
 Examiner Due to (or as a consequence of) JPERTENJION Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-tran that initiated events Due to (or as a consequence of) physician at the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🐲 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 🗆 No 1 Yes Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Inpatient 💵 ER/Outpatient 3 🗌 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 Tes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description:

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 00024970

State Registrar COURT NOAP, RANGALLSTOWN MARYL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

5401

32. Registrar's Signature

020

10-07575 Patrick W. O'Brien Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Registrar	_	g. No.	30893			
Physicia Medical Examir	ın/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month	Day Year	3. Time of Death 1056 hrs			
Medical Examin	ICI	Patrick W. O'Brien, Sr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat	October 2,	4c. County of Deat				
1		St. Joseph's Hospital Towson		Baltimore Co	unty			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr Months Days Hours Mir	2	h(MM/DD/YYYY) 9. Bi Forei	gn			
		220-52-3800 1 Mm 2 F 63 Yrs. Months Days Hours Mir	Dec. 0)9, 1946 c	ountry Mary land			
any		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lin						
land f show	ral Director	Md. Baltimore Cockeysville			1 Yes 2 No			
Mary rr 28a-		10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	•			
vith the		9606 Labrador Lane 21030 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	specify Yes or No-		ican Indian, Black,			
death v	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White,					
s after	P, F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify: 1 Specify:						
2 hour "natu		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		16b. Kind of Business	Industry			
036 ithin 7 ne.	Completed	+4 Business Owner		Sales				
Hygie d other			e (First, Middle, M					
212 212 Jild be Mental marke event	o Be	Joseph K. O'Brien, Sr. Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or		eall ber City or Town State	Zio Code)			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Mrs. Pamela O'Brien/ Wife 9606 Labrador Lane Co						
ore, land of Heal		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or				
Limo Page ment c		4 Donation 5 Other Specify: Dulaney Valley Mem 10/		Timonium,	-			
Balt permit Depart Impor injury		21. Sy nature of Funeral Service Licensee 22. Name and Address of Facility WOWS (10FC) Vower	on Funera	al Home, Inson, Md. 2.	nc.			
Physician	-1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.			Approximate Interval			
/Medical Examiner		Between Onset and Death						
zaamioi		or condition resulting in death) Due to (or as a consequence of):						
	힐	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):						
	Examine	cause. Eiter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			1			
and transit	<u>~</u>	d						
760, icate be executed physician and the burial - transit	Medical	X unpended	2/10 TT					
876 tificate ng phy as the l		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancy	23d. Date of deliver	v Day Year			
Box 687 e death certific the attending p ed for use as th	Physician/	4 Pregnant at time of death 5 Other (Specify)						
that the de detached f	ᇎ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?			
Division of Vital Records, P.O. rial or Attending Physician: The law requires that it is after death. The law requires that the state of the law been signed by all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.		Chronic alcoholism	1 Yes	2 No 3 Prob	oably 4 🗹 Unknown			
tal Records cian: The law requi certificate has been ector, page 2 should	Completed		24a, Was ar autops		topsy findings available			
Reco	E		perform 1 V Yes 2	ned? death?				
tal Recian: The certificate ector, page	Be	25. Was case referred to medical examiner? Hospital: Losting of Following of Fol						
ing Physi ling Physi After this funeral dir	인	1 Yes 2 No 1 inpatient 2 EN/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other:						
OD C ending ath. or: Aft		1 Natural 5 Pending (Month, Day, Year) 1 Yes 2 No						
Division pital or Attent ours after death teral Director: filled in by the	Certification	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town State)						
Di sepital hours a neral J	اق اق	4 Homicide determined (Specify)						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Physician: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
To with	ĕŀ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mor	nth, Day, Year)			
The day My King to and O.C.M.E. OCME OCH					ectober 3, 2010			
a. A		30. Name and address of person who completed cause of death (fterf £3a) Theodore M. King, Jr. MD. Assistant Modical Examinar. 111 Ropp Street, Reltimore	MD 24204					
χ£ηΦ Sta	to	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore 31. Date filed (Month, Day, Year).	e, IVID 21201					
Sta Registr	ar	31. Date filed (Month, Day, Year) 10 2. Registrar's Signature						

1-1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 30, 2010 Physician/ 8:05 P M LILLIAN THEOPHILIA OZAZEWSKI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A **OVERLEA** CENTER FOR REHAB & NURSIN Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Months Hours July 29 (ear) 1921 1 M 2 X Mary Land 89 220-09-5660 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ¥ Yes 2 □ No N/A Marvland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 **USA** 6238 Fernway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Force Black, White, etc. 1 X Never Married 2 ☐ Married Yes 2 X No ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Divorced 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Catholic Charities Supervisor of Adoptions Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Duda Theophilia Fred W. Ozazewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6238 Fernway, Baltimore, Maryland 21212 Emily A. Conner (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 10/2/2010 Baltimore, Maryland 21. Signatu of Funer | Savard idense TCHELL-WIEDEFELD FUNERAL HOME, INC 00 York Road, Baltimore, Maryland Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in a chine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 mont 1 Yes 2 No 9 Unknown Month Day Pregnant at time of death signed by the a d be detached f Part II<mark>. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? has autopsy performe **Director:** After this certificate I 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours af

To the Funeral D

completed filled in Medical 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number D 2539/ 29d. Date signed (Month, Day, Year) 29b. Signatu 2010

State Registrar 31. Date filed (Month, Day, Year) 0CT 0 4 2010

32. Registrar's gnature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mahomad Kahn, MD 5601 Loch Raven Blvd, Third Flr., Baltimore, Maryland 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 28, 2010 11:38 AM Edna B. O'Leary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Hospice Timonium If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 05/03/1935 Country)
Maryland 1 □ M 2 💢 F 216-30-5589 75 Director Usual Residence of Decedent or 28a-f shov 10b. County 10d. Inside City Limits permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location Director 1 🎇 Yes 2 🗆 No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21231 United States 308 S. Washington Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 XNo Specify: White If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ရ Albert Simms Minnie R. Cassel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2930 Rosemar Drive Ellicott. City Maryland 21043 Fran Howard - Sister SEPTEMBER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 10/05/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Dayid J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 . Signature of Funeral Service Licenses Part/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure.)List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC CANCER UNKNOWN PRIMARY disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to for as a consequence of thany hading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal deat
Pregnant at time of death Ectopic pregnancy in the past 12 months?
1 \(\subseteq \) Yes 2 \(\mathbb{X} \) No 5 Other (specify) Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director; After this certificate 1 Yes 2 No Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Division of Vital Other: 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 2 🗶 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 X Natural 5 Pending work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print)

State Registrar JACKIE JONES.

31 Date filed (Month, Day

CRNP

2300 DULANEY

egistrar's Signature

VALLEY RD

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:46 PM Robert C. Piereman 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 6. Sex 1 X M 2 □ F **Funeral** Days Hours June 16 **Director** 218-18-0845 86 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 108 W. 39th Street 21210 USA hours after death 12. Was Decedent Ever in U.S. Amped Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Maintenance Supervisor HVAC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Westley Piereman Josephine Eve Schultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hermitage Drive; Marrero, Theresa Anderson / daughter LA 70072 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation Other (Specify)entombment Finksburg. vergreen Mem Gardens 10/8/2010 1050 York Road 22, Name and Address of Facility MD 21204 Ruck Towson Funeral Home, Inc. Towson, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one car that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ day Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Live Birth Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for I in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nu/se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BILAL SAIRA UNION MEMORIAL 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30899 Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 523 Month Kenneth David Pindell, Sr. 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore Square osedale If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Hours Months 1 X M 2 □ F Days Maryland 67 07/17/1943 219-40-8431 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Essex 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21221 209 Magnolia Terrace 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 🙀 No Specify. Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Highway Construction Construction Worker 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Pindell Helen King 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 Magnolia Terrace, Baltimore, Maryland 21221 Regina Pindell (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. 10/05/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Short the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseasé or condition resulting in death) eps s Du no (or as a consequence of): neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last DIRATION Due to (of as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Veal 5 Other (specify) 9 I Unknown her significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an decubitus ulcer8 1∐Yes 2 No 1 □Yes 2 ☑No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

Physician /Medical **Examiner** that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, attending physician for use as the buria

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show

the Medical

Director

Funeral

2

Completed

Be

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death with the Maryland

filed within 72 hours after

1 and 2 should be f Health and Mental is marked

27

permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr

Maryland 21215-0036

Baltimore,

Examine Physician/Medical \$ Completed Be Certification: To

detached

director, page 2 should

filled in by

completely

certificate

this funeral

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e Hospital of 24 hours at Euneral D

within 2

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Avatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) of certifier 29b. Signature

SAMIEC

29d. Date signed (Month, Day, Year)

s of person who completed cause of death (Item 23a) (Type, Print) Name and addre Manklin Square Drive Baltimore, MD 21237 9000 Samilee

Year)

Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 State of Maryland 9 621/110 meth of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year TOBPR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SALTIMORE TER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign Social Security Number 2 2 3 - 18 - 6611 **Funeral** Month, Day, Year) 1922 1 □ M 2 🛛 F Months Min. Yrs Maryland Director 88 August Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Parkville Md. Balto. 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 15 Eastford Court 21234 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 √ No Specify: Specify: Completed White 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown Theodore Matuszak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 Robin Ridge Court Parkville, Md. 21234 Ken Pivec Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗶 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, Gardens of Faith 10-5-2010 Balto. Md. 21206 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Schimunek FuneralHome 22. Name and Address of Facility 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between nset and Death Immediate Cause (Final Physician/ INTRACORPBRAL disease or condition Medical resulting in death) **Examiner** YPERTOWSION Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use cogtribute to the cause of death? þ COROWARY ARTERY DISCASE 1 Yes 2 ✓ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of SEIZURE DISORDER 24a. Was an has autopsy death? within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page Yes 25. Was case referred to medical examiner?

1 Yes 2 No To Be 26. Place of Death (Check only one) HOSPICE Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

Registrar
DHMH 17 Rev 7/2009

State

and address of person who completed cause of death (Item 23a) (Type,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#23a, Pt1, ITperPHYS, G908, 10/26/2010, WS

State of Maryland / Department of Health and Mental Hygiene | | | | 3090 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Norvo Month 2 5.09PM 2011 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4b. City. 4c. County of Death **Examiner**) fino onte 100 8. Date of Birth (Month, Day, Year a If Unde Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 XXXI 2 □ F Months Davs Hours Min. Country) 399-20-9547 Director 83 sconsin Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director Maryland 1 Yes 2xx No Anne Arundel **Gambrills** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2168 Branchwood Ct. 21054 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1945–1946 1 ☐ Yes 2 🙀 No Specify: Specify: white Completed 3 Widowed 4 Divorced and Mental Hygiene.
Is marked other than "natur aumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12th Trucking Company Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carl Rude Mildred Berg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma L. Rude 2168 Branchwood Ct. Gambrills, MD wife 21054 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1XXBurial 2 ☐ Cremation 3 X Removal from State Pine Grove Cemetery Oct. 16, 2010 Cameron, Wisconsin 4 Donation 5 Other (Specify) any inj once, 21. Signature of Funeral Service Licen-Burrier-Queen Funeral Home & Crematory, PA 1212 W. Old Liberty Road Winfield, MD 21784 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ regornation adorcan mote disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Aspiration Pneumonia attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury Divoltio p that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death signed by the at d be detached for Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ tiple 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Valvular heart disease After this certificate has funeral director, page 2 t autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 🗌 Yes ည 🚺 Inpatient 2 🗌 ER/Outpatient 3 🗎 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Manner of Dath 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending
Investigation thin 24 hours after death.

the Funeral Director; Af ompleted filled in by the fu Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and Baltwork, Medical Conter 10 N Granost 1402101 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19a, per Fh. G908 10/5/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ ORNARD OWLET OCTUBOR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months (Month, Day, Year) 1 X M 2 - F 6 Director Usual Residence of Decedent 10a. State : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland 1 Yes 2 No alt imore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1236 4010 aylor Uznue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Yes, Give Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: 3 🗌 Widowed 4 🗀 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mary land State ouse Be permit. Page 1 and 2 should be filed value to the permit of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Grace Johnson Bernard 19a Informant's Name/Relationship (Type, Print)

Name/Relationship (Type, Print)

Rowlett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) lar Au Baltimore, Margland Tay Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 8,2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Calvin I. Will 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by PROSTATE CANCER 1 Yes 2 No 3 Probably 4 Unknown STEROID INDUCED TYPE 2 DIABOTOS MOLLIT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) HOSPICE examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

Physician/ Medical Examiner

Physician/

Medical

10a. State

MD.

Director

Funeral

Completed by

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Examiner

Funeral

Director

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Page 1 and 2 should be filed within 72 hours after death with the Maryland

nd Mental Hygiene. marked other than "natural";

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I

Baltimore, Maryland 21215-0036

the attending physician and thed for use as the burial-transi Division of Vital Records, P.O. Box 68760

Completed by Be ٩

completed filled in by the funeral director, within 24 hours after deat To the Funeral Director: State Registrar

21. Sign Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Unknown Part II. Other significant conditions contributing to. 25. Was case referred to medical examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nd title of certifier 29b. Signature

DHMH 17 Rev 7/2009

31. Date filed (Nonth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #5 Per FH G908 10/29/10 JH. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2010 Year **Physician** Oct. Mary Alice Sullivan 1, 12:44 pm^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Lorien Nursing & Rehab. Center Taneytown Carrol1 5. Social Security Ng250 If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 👿 F 87 212-20-9496 Director July 1, MD 1923 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 1 Yes 2 No Director MD Carroll Taneytown 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? a or 154 Saddletop Drive 21787 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 27 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No 2 Specify Specify: White 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Farmer/School Bus Contractor Agriculture/Transport 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be C1yde Seibert Nettie Willis 2 19a. Informant's Name/Relationship (Type. Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Peggy Sullivan Kruhm 147 Saddletop Drive Taneytown, MD 21787 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o once. A Burial 2 ☐ Cremation 3 ☐ Removal from State 10/5/2010 4 ☐ Donation 5 ☐ Other (Specify) Mt. View Cemeterv Marriottsville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 21. Signature of Funeral Service License & He MO0764 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical in to (or as a con a guence of Examiner Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of) -burial-Division or Vital Records, P.O. Box 68760, physician a Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 ☐ Yes 2□ No 2 NO Yes or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA nours after death.

neral Director: After this
y filled in by the funeral d this 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year 5 Pending investigation 1 🔲 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29d. Date signed (Month, Day, Year) 32. Registrar Date filed (Month, Day, State OCT 0 4 2010 Registrar

DHMH 17 Rev 1/2001

- per Truck

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George Month Year David Saunders October 0 2010 Medical :09a 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carrol1 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) ent 4 1944 Months Days Hours Min 216-48-8956 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified to once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carrol1 Sykesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4500 Raymond Avenue 21784 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: white 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) emergency services firefighter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Noble Saunders Helen Louise Hatfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Diana L. Saunders (spouse) 4500 Raymond Ave., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial 10-6-10 Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel · Paracofaight P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cance disease or condition Medical resulting in death) Due to (or as nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Felan GO.
☐ Pregnant at time of death
☐ Unknown 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year cate has been signed by the a page 2 should be detached for g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No eral Director: After this certificate filled in by the funeral director, pag 1 Yes 2 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital. 2 X No Other: 1. Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, within 24 hours a To the Funeral C Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month. Day, Year) 2010

DHMH 17 Rev 7/2009

State

Registrar

beorgetour

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

0 4 2010

0190

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Carroll Stevenson Joyce October 4:15pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Carroll 4b. City, Town, or Location of Death Transitions Health Care Sykesville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Month, Day Y OC. 18 Months Days Hours 69 Director 213-38-8971 Yrs. Dec. 1940 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ortant: If item 27 is marked other than "natural", or items be notified at injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Sykesville MD Carroll 1 ☐ Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21784 USA 4414 Carroll Park Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Property Manager Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dorothy Mae Carroll George Kenneth Wetzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 4414 Carroll Park Ct., Sykesville, MD 21784 Mr. Cecil C. Stevenson (Spouse) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 10/8/2010 Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith of Funeral Service Lie 21. Signature 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician mentra disease or condition DOCC Medical resulting in death) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery Live Birth 2 Live Service 2 Pregnant at time of death Unknown 3 Ectopic pregnancy in the past 12 month cate has been signed by the atte page 2 should be detached for a 5 ☐ Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy hours after death. **uneral Director:** After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🗹 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🔲 Yes 2 No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2115 ilbu

_____/DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 30907 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stansfield Ottober 2 2010 ar Joan Greenlee 7:45am M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Fairhaven Health Care Center Sykesville Carroll Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)

TT **Funeral** 1 □ M 2 👿 F Days $J_{\rm ul}^{(Month, Day}$ $29^{(Year)}$ 1929322-24-1886 81 Yrs TL **Director** Usual Residence of Decedent shov or 28a-f shov notified at 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits MD Carrol1 Sykesville 1 Yes 2 No 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o with t Funeral 7200 Third Avenue 21784 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🕅 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: White Specify Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Greenlee Mildred . Boardman 19a. Informant's Name/Relationship (Type, Print) (Spouse) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Norwood V. Stansfield, Jr. 7200 Third Avenue, Sykesville, MD 21784 Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. View Cemetery 10/5/2010 Marriottsville, MD . Signatur of Funeral Service Ligenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ ascular disease or condition Medical resulting in death) Examiner Sequentially list conditions, if the conditions of the cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and resulting in death) Last Due to for as a consequence of attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months? Dav Year Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number D34849 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eldersburg MD 21784 William Tan 1645 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 11:30 ichard September Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospital Carrol) MD Center Westminster Carrol 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F Months (Month, Day, Year) une 1, 1929 Hours Maryland Director 81 June 218-24-8980 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Carroll Union Bridge 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21791 U.S.A 8 S. Benedum St. "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1

Yes 2 □ No
If Yes, Give Black, White, etc. 1 ☐ Never Married 2 🔀 Married Ď, within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Specify: Completed Year or Dates. 1948-52 White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 carpenter cement co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည E. Earl Stultz Florence Rebecca Baile 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Union Bridge, MD 21791 E. Yvonne Stultz/ wife 8 S. Benedum St. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit, Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 5 1 XBurial 2 Cremation 3 Removal from State injury (St. Paul's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 10/2/2010 Uniontown, MD 21. Sign of the ral Service License 22. Name and Address of Facility Hartzler Funeral Home Union Bridge, MD \mathbf{E} Broadway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Intracerebral Hemorrhage disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner MALI Gequentiary list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Year 1 Yes 2 9 Unknown a Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 24 hours after death. 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should it. 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed' 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗆 No ၉ 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred Fell from Strong 10511 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending sentember 26,200 1600 P Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rutal Route Number, City or Town, State) & Benediam Street determined Uniou Bridge MD 21791 Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier WN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, Westminster 200 Memorial Carroll Hospital Center . Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 October 1, Shively James Rov 8:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1824 Beechwood Avenue **Essex** Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (I/Onth, Day, Year)

Months Days Hours Min. Ut/Onth, Day, Year)

July 28, 1951 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗖 M 2 🗆 F Mary Land **Director** 219 56 6545 Yrs 59 Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland | Baltimore 1 🗆 Yes 2 🖵 No **Essex** 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? with Funeral 1824 Beechwood Avenue 21221 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 Divorced Specify: White er than "natur the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry Page 1 and 2 should be filed within 7 ment of Health and Mental Hygiene. tant: If item 27 is marked other than iury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ဥ Roy James Shively Ellenberger Erma Jane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Shively 1824 Beechwood Avenue Essex Maryland 21221 (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place permit. Page 1 s
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State Dulaney Valley Mem. 10/5/2010 | Baltimore County, Md. 21. Signature of Function Bruzdinski Funeral Home PA 22. Name and Address of Facility 1407 Old Eastern Avenue Essex Maryland 21221 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final Physician. Onset and Death GLIOBLASTOMA MULTIFOME disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 6 ma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). signed by the attending physician and dedetached for use as the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? Month Pregnant at time of death Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 124 hours after death.
124 hours after death.
124 hours after death.
124 hours after death.
125 hours after death. 1 Yes 2 No Yes 2 No 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? 1 Tes 2 🔼 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

30. Name and address of person who

JOSEPHS

OSLER DI. 32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

TOUSON, MD

29c. License number D26637

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 3 2010 201 Philip Robert 4:30 Sauerwald PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Stella Maris Hospice Baltimore Timonium 8. Date of Birth (Month, Day, Year) 03/31/1941 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Min. 1 € M 2 □ F Hours Director 220-36-0275 Maryland Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Maryland Baltimore Parkville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8818 Avondale Road 21234 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. ģ 1 Never Married 2 Married 2 **XX**No Yes 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Completed 3 Widowed 4 Divorced White Year or Dates 16b. Kind of Business Industry Baltimore County Fire Department 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Firefighter is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2010 ဂ Robert L. Sauerwald Edna V. Wolf injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is n Cheryl Sauerwald (Wife) 8818 Avondale Road, Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State CTOBER 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 10/06/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A Signature - aneral service Licensee Old Eastern Avenue, 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final Physician/ END STAGE RENAL DISEASE disease or condition Medical esulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Cause (Disease or linjury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): iding physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Hospital or Attending Physician: The law requires that the death Month Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown SAUERWALD Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to be det þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has to page 2 s autopsy ROBERT perform 2 X N certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\mathbb{X} \) Other (Specify) Hospital: 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ပ HOSPICE this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury 5 Pending X Natural 1 Yes within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 U Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License numbe 29b. Signature and title of certif 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 JACKIE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 4 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Amanda Rose Ste		ns Stat I-For State		and / De	epartment o Certificate o	of Health ar		Hygiene	201	0 30911		
Physician		Registrar 1. Decedent's Name (First, Middle,L	.ast)		-			2 Date of Dea	eg. No.	3. Time of Death		
Medical Examine		Amanda Ros		evens				Month September	Day Year er 30, 2010	0733 hrs		
		4a. Facility Name (if not institution,	give street and nu	imber)		4b. City, Town, o			4c. County of	Death		
		27 N. Main Street #8				Union Brid			Carroll			
Funeral		, , , , , , , , , , , , , , , , , , , ,	Sex	7. Age (In y	yrs. last birthday)	If Under 1 Ye Months Da		Hrs. 8. Date of Bi	rth(MM/DD/YYYY)	Birthplace (State or Foreign		
Director		220 72 1750	M 2XF		32 Y	rs.	,	July	1 , 1978	Country)Maryland		
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the Maryland a or 28a-f sh lifted at onc	ě	27 N. Main St.				21791				S.A		
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her de la la la la la la la la la la la la la		3 Widowed 4 Divorced If Yes, Give Year				1 Yes 2 No specify: Specify: Whi						
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21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	ğ	Bruce Wayne St 19a. Informant's Name/Relationship		_	19h Maili	na Address (Stre		usan Phi] or Rural Route Nur		State Zin Code)		
MD 21 nd 2 should ulth and Me m 27 is man aumatic ev		Susan Buffington			T I					ge,MD 21791		
	-	20a. Method of Disposition	i/ moener		20b. Place of Dispo	sition (Name of co		Date Date		City or Town, State		
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Balt permit. Departt Import	ı	(atharine)	. Har	Dler		E. Broa			idge, MD			
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Medical Examiner	ŀ			ve ai	rway dis	ease				Death		
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Box 68760, e death certificate be the attending physici of for use as the buri-		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes,	outcome of	pregnancy	etal death 3	Ectopic pre		23d. Date of d Month	Day Year		
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P.O. E that the comed by the detached by Phy		Part II. Other significant condition Increased car	s contributing to diac fib	rosis	not resulting in the with ri	underlying cause ght	given in Part I.	23e. Did to		ute to the cause of death? Probably 4 Unknown		
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cords, law require has been a 2 should	Completed	ventricular d	ilatatio	n; ob	esity			autor	osy pr	for to completion of cause of eath?		
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ding Pl		27. Manner of Death 1 X Natural 5 Pending		Day,Year)	28b. Time of		Yes 2 No		now injury occurre			
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Division of Vital Records, P.O. spital or attending Physician: The law requires that th tours after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detact. Certification: To Re Completed by P.		3 Suicide 6 Could n	ot be	o or injury	7 (10110, 10111, 00	oot, ractory, omoo	Danianig, oto.	or Town, S		,		
Tospit 4 hour huner.		4 Homicide 29a. Certifier 1 Certifying Physics	ician: To the bes	at of my know	wledge, death occ	urred at the time, o	date and place,	and due to the caus	se(s) and manner a	as stated.		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring Afficial Certification: To Be Completed by Physician/Medical Certification:	8	one) 2 Medical Examí	ner:On the basis of	of examinati	ion and/or investig	ation, in my opinio	n, death occurr	ed at the time, date	and place, and du	e to the cause(s)		
F 18 6 8	₽ŀ	29b. Signature and title of certifier	and mariner's	<u></u>		29c. Licen	se number		29d. Date signed	(Month, Day, Year)		
(M. hine	Al de			O.C	.M.E.		September :	30, 2010		
	t	30. Name and address of person wh	1 .									
4		<u> </u>	Assistant Me			Penn Street,	Baltimore, N	/ID 21201	<u></u>			
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DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Howard Spencer 25 AM October Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Four Seasons Hospice NWH RandallsTown Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 26, 1945 **Funeral** 9. Birthplace (State or Foreign Hours Min. Days Mary land Director 216-44-5698 Yrs. Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant. If item 27 is marked other than "natural", or items 23a or 28a-f sho at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits notified MD Anne Arundel Anne Arundel Count 1 Yes 2 No 10e. Street and Number ral", or items 23a or Examiner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral Park Arenue U.SA 21225 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Specify: Black or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ haurence L. Spencer Beatrice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margret Dorethea Edwards 403 W. Ordanance Rd Apt 324 Glen Burnie 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 s Department of H Important: If ite 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State injury o 4 Donation 5 Other (Specify) catonsville Metro Crematory Oct 4, 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Runard H. Sprfyson Funeral Service
270 Fred Huttin Pass, Bactimore, MD any Ronald aim MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ CardioThrombotic Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Atheroscherotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be execute attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month / the & hed fu Day Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed?/ Yes 2 No certificate 1 Yes 2 🗌 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 Tes 2 🖸 No 4 Nursing Home 5 Residence 6 Other (Specify) ၉ Other: 1 Inpatient 2 ER/Outpatient 3 DOA After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? injury Accident 2 🗌 No Investigation 24 hours after deat Funeral Director: filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 🗆 within 2 To the only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) MSRajapahreM.D D0057465 10/2/10

State Registrar

Smith Av. 5-203.

Baltimore, MD. 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. KajapaKH, M.O. 2835

N.S. Rajapakse, M.O.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Per FH C908 10/06/10 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JOHN MILTON SEWELL Medical September 29,201 . 37 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Cente: Baltimore **Funeral** If Under 1 Ye Age (In vrs. last birthdav) 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7/Month DavoYear 1 **X** M 2 □ F Months Days 219-36-4058 69 Director Panama 07/28/1941 Usual Residence of Decedent Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Cockeysville 1 Tes 2 No <u>Baltimore</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 869 Ivy Hill Road 21030 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Engineer Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Milton Asbury Sewell Frances Neighbors 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cherie Jacqueline Sewell Wife 869 Ivy Hill Road Cockeysville Maryland 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Donation 5 Other (Specify) GreenMount Crematory 10/02/2010 Baltimore, Maryland nature of Funeral S 22. Name and Address of FMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease or complice shock, or heart failure. List only one thins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death endomonas disease or condition Medical resulting in death) Examiner hem, thera Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery been signed by the atte should be detached for in the past 12 months? Month Day Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ hy m phome Completed 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 No 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury 2 🗌 No Investigation 1 Tyes 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mari 09 19 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 70 North Charles

State

Registrar

31. Date file

32. Registrar's Sign

I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#5 PerFH G909 11/03/10 Jh
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Medical 30 8.46 AM 20/0 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Patuxent River Health & Rehab. Laurel Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Y.
NOV • 18, **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Year 1930 1 □ M 2 □XF Director Yrs Country) Michigan Usual Residence of Decedent show . Page 1 and 2 should be filed within 72 hours after death with the Maryland iment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f shoi jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George's Laurel 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6406 Sandy Street 20707 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3XXWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Banking Clerk Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Albert Kaminski Brodowski Sophie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Marie Traskie/Daughter 6406 Sandy Street, Laurel, MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 10/6/2010 Odenton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, M01103 313 Talbott Avenue, Laurel, MD 20707 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onsel and Death disease or condition (EROLDER Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day ate has been signed by the page 2 should be detached Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【CUnknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? After this certificate 1 Yes 2 No Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes 은 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Could not be Accident within 24 hours after deat To the Funeral Director: 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number D0062534 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 03 Ellicol 9055 Cherrole DHAWAN 31. Date filed (Month, Day, Year) 32. Registrar's Sig State OCT U 4 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9: 2/AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MOTE ano If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth 7. Age (In yrs. **Funeral** 1**X**XM 2 □ F Director 216-92-1645 45 MD Usual Residence of Deceden "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** 1 Yes 2 K No Carroll MD Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21797 USA 7212 Woodbine Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★★No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify. Specify: 3 Widowed 4 Divorced White Completed any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Plunkert Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H ည Virginia Lucille Mayne Dennis Ray Tomlinson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 7212 Woodbine Rd., Woodbine, MD 21797 Catherine Tomlinson/Wife Department of Hea Important: If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/5/2010 Poplar Springs Cem. Poplar Springs, MD Signature of Funeral Service Licensee Burrier Outeen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ To the Hospital or Attending Physician: The law requires that the death or within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter in the past 12 months? completed filled in by the funeral director, page 2 should be detached for Month Pregnant at time of death Day Year Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 🗖 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No Inpatient 2 ပ ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) eenp 39/timos State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Marshall Steiner Wise, Sr. 3:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) 03/19/1926 Maryland 1XXM 2 □ F Director 219-14-1015 84 Usual Residence of Decedent show or 28a-f shov notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location with the Maryland Director Baltimore Essex Maryland 1 Ves XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a or ner must be n ō Funeral U.S.A. 21221 86 Ginwood Lane within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status er than "natural", or ite Black, White, etc Armed Forces? ģ 1 Never Married 2 Married XYes 2 No Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: White WWII Completed 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Plumbing Plumber Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) a 1 and 2 should be filed of Health and Mental H fitem 27 is marked ot rother traumatic even ပ္ Agnes Lulu Whittington Marshall Lee Wise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 86 Ginwood Lane, Baltimore, Maryland 21221 Mildred E. Wise (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2XXCremation 3 Removal from State Bayview Crematory, Inc. 10/04/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Gravice Licensee ^{22. Name and Address of Facility}
Bruzdzinski Funeral Home, P.A.
1407 old Eastern Avenue, Essex, Maryland 21221 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between ediate Cause (Final triple Physician down Medical resulting in death) Que to (or as a consequence of) Examiner Se mentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) umonar The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and -trar Due to (or as a consequence of): burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnan Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) bed 1 9 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 No certificate 1 Yes 2 No Hospital or Attending Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ After this funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: A 2 Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one)

State Registrar 31. Date filed (Month, Day, Year) OCT 0 4 2010

29b. Signature and title of certifier

Union egistrar's Signature

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Temorin 29d. Date signed (Month, Day, Year)

Oct. 01.2010.

(3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Theodore 2ďľo 12:21 A.M James Zottola Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Baltimore Towson . Sex 1 X M 2 □ F If Under Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** (Month, Day, Country) Utah Hours Months Min 046-18-1712 Director 85 924 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matter once. 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Florida Manatee Bradenton 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 6503 Auburn Avenue 34207 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black White etc. 1 Never Married 2 X Married Completed by Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏋 No Specify Specify: 3 Divorced Year or Dates. WWII White 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 4 vears Sales Textiles Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ethe1 Wendell Michael Zottola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Zottola (wife) 6503 Auburn Avenue Bradenton, Florida 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-1-10 Baltimore, Maryland Green Mount Crematory 21. Signature of Funeral Service Licensee Mitchell-V 6500 York ress of Facility -Wiedefeld Funeral Home, Inc. k Road Baltimore, Maryland 21 23a. Part 1. Euler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director; After this certificate has autopsy perform 1 🗌 Yes 2 🗎 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Suicide
Homicide l in by 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direct Medical Gertifiel 🜠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on Signatur title of certifier 29d. Date signed (Month, Day, Year) 21204 and address of person who completed cause of death (Item 23a) (Type 2

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30919 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HELEN ELIZABETH BRAUCHLE ASMUSSEN 0300 M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Memorial Easton Hospital lalloct If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Hours 1 M 2 X F Months Days 83 02/09/1927 <u>21</u>8–20–2997 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No TALBOT TRAPPE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29281 MAPLE AVENUE 21673 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 SECRETARY OFFICE ADMINISTRATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CARL O. BRAUCHLE, SR. MARY E. BRADLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ERIC S. ASMUSSEN/SON 29272 MAPLE AVE., TRAPPE, MD 21673 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State WHITEMARSH CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 9/08/2010 TRAPPE. MD 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 200 S. HARRISON ST., EASTON, MD 21601 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heart orgestive cars Due to (or is a consequence of) hvonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 5mohing ROVS Due to (or as a conseque a of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 √Yes 2 No 3 Probably 4 Unknown Ras

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "attent the Medical Examination or other traumatics event, the Medical Examination and the content.

Baltimore, Maryland 21215-0036

Box 68760.

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Records,

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/Medical

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MD

Director

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burial-trar physician certificate be use Ď ed by the a signed I page 2 should has certificate After

Exami Physician/Medical þ Completed Be P e Hospital or Attending Pi 124 hours after death.
e Funeral Director; After the letely filled in by the funera Certification:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown

autopsy performed 1 □ Yes 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 Yes 2 √No 27. Manner of Death 1 Natural

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day, Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 □Yes 2 □ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a, Certifier (Check only

2 Accident

4 Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 442587

29d. Date signed (Month, Day, Year) 09-03-2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

555 Schilling Growood Ar Easton m.D.

07 2010

32. Registrar's Signature

Registrar

within 24 hours aft

To the Funeral Di

completely filled in

To the I within 2 To the I

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

30920

Physician/
Medical
Examiner

Baltimore, Maryland 21215-0036

Physic Me Exan

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760

4b. City, Town, or Location of Death WILLIAM HILL MANOR 5. Social Security Number 6. Sex 1		Registrar				Cer	imcate	OI DE	aui		Re	g. No.					
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28 - 18 - 468 1	ner 4a. Facility Name (if not institution, give street and number)						4b. City, Town, or Location of Death					4c. County of Death					
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17. Father's Name First, Middle, Last)				If Yes, Giv	ve	1						Specify: WHITE					
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NANCY L. ALDRICH/DAUGHTER 311 COLESVILLE MANOR DR., SILVER SPRING, MD 2090				•								aiden Surna	me)				
20a. Method of Disposition 1					ER		-					-			20904		
21. Signarity of Funcial Service Licensee 22. Nature and Address of Facility 22. Part 1. Erier the disease, or complications that crisised the death. Do not enter the mode of disease, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause shall be a shock, or hear failure. List only one cause shall be a shock or hear failure. List only one cause shall be a shock or hear failure. List only one cause shall be a shock or hear failure. List only one cause shall be a shock or hear failure. List only one cause shall be a shock or hear failure. List only one cause shall be a shock or hear failure. List only one cause shall be a shock or hear failure. List only one cause shall be a shock or hear failure. List only one cause shall be a shock or hear failure. List only one cause shall be a shock or hear failure. List only one cause shall be a shock or hear failure. List only one cause shall be a shock or hear failure. List only one cause shall be a shock or hear failure. List only one cause shall be a shock or hear failure. List only one cause shall be a shock or hear failure. List only one cause shall be a shock or hear failure. List only one cause shall be a shock or hear failure. List only one cause shall be a shock or hear failure. List only one cause shall be a shock or hear failure. List only one cause shall be a shock or hear failure. List only one cause shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shall be a shal				2 Pomoual from	20b. F				-								
200. Figure 12 Live Birth 2 FEMALE: 226. If yes, outcome of pregnancy that inflated events resulting in death; 20 21 22 23 24 24 25 25 26 26 26 26 26 26		4 Donation	5 Other (S	Specify)	CHI CHI	ESAPEAI CENT	CE CRI	EMATI	ON 09	/14/:	2010 5						
23a. Part 1. Enter the disease, or complications that officed the death. Do not enter the mode of dyine, such as cardiac or respiratory arrest, shock, or heart failure. List orly one cause and hine. Immediate Cause Final resulting in death) 25. When the death of the complete of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause o		21. Signature of Fi	Ineral Service I	M. A	yona	F1	ELLOW:	HARR HARR	LFENBI LSON S	EIN &	& NEWNA EASTOR	M FUN	ERAL 1 2160	HOME,	P.A.		
Due to (or as a consequence of): Due to (or as a consequence of):		shock, or hea	art failure. List o		ch line.	h. Do not ente	er the mode	of dying	such as card	diac or re	spiratory arres	t,		Approxin	nate Between		
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (becase or linury resulting in death) Last Due to (or as a consequence of):	1	disease or conditi	on	_ a +	ull	10N	ARY	1	1 VBR	051	.5			Unset an	Death		
Due to (or as a consequence of): Cause (Disease or linjury resulting in death) Last		resulting in death)		Due to	(or as a consequ	uence of):	= '										
FEMALE: 23b. Was decedent pregnant 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year 1 Yes 2 No 3 Probably 4 Unknown 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an exampler? 1 Yes 2 No 3 Probably 4 Unknown 25b. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 25b. No 1 Yes 2 No 25b. No 1 Yes 2 No 25b. No 1 Yes 2 No 25b. No 1 Yes 2 No 25b. No 1 Yes 2 No 25b. No 1 Yes 2 No 25b. No 1 Yes 2 No 25b. No 1 Yes 2 No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b. No 25b.	Jer	if any, leading to in	mmediate		(or as a consequ	uence of):											
FEMALE: 23b. Was decedent pregnant	ami	Cause (Disease or	r iinjury														
In the past 12 months? 1				Due to	(or as a consequ	uence of):											
In the past 12 months? 1	edic			d													
1 Yes 2 No 3 Probably 4 Unknote 24a. Was an autopsy findings availabe prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 26. Pla	ysician/M	23b. Was deceden in the past 12 1 ☐ Yes 2	months?	1 🔲 Live 4 🔲 Preg	Birth 2 🗆 Feta nant at time of c	al death 3			- 10.00					*	Year		
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature applittle of certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	y Ph	Part II. Other signi	ificant condition	ns contributing to c	leath but not res	sulting in the u	nderlying c	ause giver	in Part I.		23e. Did toba	acco use co	ntribute to th	ne cause c	f death?		
26. Place of Death (Check only one) 27. Manner of Death Natural 2 Accident 3 DOA	ed b					_				_	1 🗆 Ye	s 2 💢 No	3 🗆 Prol	oably 4 l	Unknov		
25. Was case referred to medical examiner? 1	mplet									_	autopsy	,	prior to co death?	mpletion o	gs available of cause of		
examiner? Continued Conti		25 Was case refer	red to medical					OC Disc	D (C	Charles	1 Yes 2	No	1 🗆 Yes	2 X No			
27. Manner of Death Natural 2 Accident 3 Suicide 4 Homicide 28e. Place of Injury 28e. Time of injury 28e. Time of injury 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29c. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifician 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signe		examiner?		Hospital:				Other	502.								
29a. Certifier (Check only one) 29b. Signature and title of certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier (Month, Day, Year) 29c. License number (Month, Day, Year) 30. Name and address of paron who completed cause of death (Item 23a) (Type, Print) Paramoner (Check 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number (Paramoner (Month, Day, Year)) 29d. Date signed (Month, Day, Year)		27. Manner of Dear	th 5 🗌 Pendir	of injury	t 2 LER/Outpatient 3 LDOA 4 Nursing Home 5 L Residence 6 L Other (Specify) 28b. Time of injury at work? 28d. Describe how injury occurred												
29b. Signature and title of certifier ATTENANG MD DOOS 3094 9-13-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PANN M-REINBOND 321 BLOOMING DAVE AUE (FEDRALS BUE) MI		3 Suicide	6 Could		reet, factory, office 28f. Location												
29b. Signature and title of certified ATTENDING MD 29c. License number DOOS 3094 9-13-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARM M-REINBOWD 321 BLOOMING DAKE ARE FEDRING BURGER.	Medica	29a. Certifier (Check only one)	1 Certifying 2 Medical E 3 Certifying	Physician: To the becaminer: On the base Nurse Practioner:	pest of my know sis of examination To the best of my	ledge, death on and/or invest y knowledge, o	occured at t ligation, in m	he time, day ny opinion, ed at the ti	ate and plac death occurr ime, date and	ce, and du red at the d place, a	ue to the caus- time, date and nd due to the c	e(s) and mar place, and c ause(s) and	nner as state due to the cau manner as st	d. use(s) and ated.	manner sta		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL M. REINBOUD 321 BLOOMING DAVE AUE (FEDENTLS BUZE, M) 31. Date filed (Month 1998 Beach 1999 and 1999 Replicator's Signature)	_			100											0		
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		31. Date filed /Mon	the man		SCI	SCOP!	AIN	1017	VZP	406	けそしな	W)L	5 5 02	0,0	7.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 16, Eugene Raynard Alexander 2010 3:25 am M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Carroll Carroll Hospice Dove House Westminster 8. Date of Birth (Month, Day, Apr 10 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 X M 2 🗆 F Months Days Hours 73 ^{Year} 1937 214-34-1712 Director Apr Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Eldersburg Maryland Carroll 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6159 Monroe Avenue 21784 USA death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ 1 Yes If Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white "natural" Completed 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Lutheran Church Lutheran Minister Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Raynard Alexander Anna Viola Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6159 Monroe Ave, Eldersburg, MD 21784 19a. Informant's Name/Relationship (Type, Print) Constance Ann Alexander, wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Semater) crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 9/20/2010 Winfield, MD Carroll Crematory 4 Donation 5 Other (Specify) Signature of Funeral Service Licen Ce 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part 1) Enter the disease, or complications that c shock, or heart failure. List only one cause on e Enter the disease, or complications that caused the death. Do not enter the mode of alying, such as cardiac or respiratory arrest, Approximate Interval Between nterval between Donset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, from the light cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to lor as a consequence of sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) jo in the past 12 months? Month Year Pregnant at time of death 2 No Yes 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed rOND ATTV DISCHE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to hedical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 Other: 4 Nursing Home 5 Residence 6 Other Spice 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or recovery within 24 hours after death.

To the Funeral Director: After this recovery and the funeral billing to the funeral billing of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the fun 27. Man r of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ce

Registrar

30. Name and address of pe

SEP 17

JUSTER , MB 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** mar 12 2010 /Medical County of Death 4c sility Name (If not institution, give street and number) Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1 □ M 2 □XF Oct. 9, 1931 D.C. 579-44-3165 78 Director Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland i Health and Mental Hygiene. 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County ıral", or items 23a or 28a-f shov Examiner must be notifled at 1 ☐ Yes 2 No Montgomery Silver Spring Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 3111 Weller Road 20906 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🖾 No Specify. Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Bernard Ostermayer Eugenia Williams ဥ 19a. Informant's Name/Relationship (Type. Print)

Janet R. Griggs/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl ment of Health and lant: If item 27 is r jury or other traur 12696 Fakhre Court, Mt. Airy, MD 21771 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Department o Important: If i any injury or Sept. 16 Parklawn Memorial Park Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Bater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a nonsequence of). Examiner burial-transi requires that the death certificate be execute Due to (or as a consequence of): Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? ρ 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached 1 9 Unknown s been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Yunknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy perform 1□ Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death Check only one director Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 2 ER/Outpatient 3 DOA 1 T Yes 1 Inpatient ို funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Division or Vital Records, or Attending the Hospital

Maryland 21215-0036

Baltimore,

Box 68760,

P.O.

State Registrar 29b. Signature and title of certified

7115 MD

nth, Day, Year)

1 6 2010

DHMH 17 Rev 1/2001

29c. License number

710 Obrick+ Road

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Claire Bieber Stept. 170ay 2010 ear 6:49a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1801 East Jefferson St.#237 Rockville Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4 / 25 / 1919 **Funeral** 9. Birthplace (State or Foreign 132-12-1672 Days Hours Director Usual Residence of Decedent or 28a-f shov notified at show 10a. State 10b. County within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits Rockville MD Montgomery 1 ¥ Yes 2 □ No 10f. Zip Code 20852 10e. Street and Number ò 10g. Citizen of What Country? r than "natural", or items 23a o Funeral 1801 East Jefferson St. #237 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Specify 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Supervisor Electrical Union ge 1 and 2 should be filed wit tof Health and Mental Hygie If item 27 is marked other or other traumatic event, <u>tr</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>0</u> Max Schwartz Caroline Segal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Bieber/Son 9502 Greco Garth Columbia, Maryland 21045 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Riverside Cem. 20c. Location - City or Town, State Baltimor permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 X Removal from State 9/19/2010 Saddle Brook, N.J. 4 Donation 5 Other (Specify) 21. Signature Funeral Servi PHTEIP OF RINKLDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ on agentive disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner HTN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed TAXIP that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery Month Dav Year 1 ☐ Yes 2 ≥ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed' 1 Yes 2 No Yes 2X No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital. 1 Yes 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred **X**Natural 5 Pending s after death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge death continued at the films, date and place, and due to the cause(s) and manner accepted. (Check within 2 To the I id at the films, data and place, and due to the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) rO Sept.17,2010 D 69568 ND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1801 E- Jefferson St, Packville, MD 20852 A. Chilakamass MD

State Registrar 31. Date filed Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. < 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 September Snow Miller Bishop 2:05 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Clarksville 5808 Trotter Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Jan 20, 1914 Social Security Number g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Days Months Min. Hours 1 □ M 2 🔽 F Virginia Director 96 223-18-5238 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 No Maryland Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21043 United States 8420 Horseshoe Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes Give Specify: 3 X Widowed 4 Divorced White Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) <u>Assistant Manager</u> 9 Food Service Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Shuffleberger Childress Frank Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garland Miller/son 8201 Hilton Road Laytonsville, Maryland 20882 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 9/21/2010 Woodbine, Maryland Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Urosepsis Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Month 1 Yes 2 been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Debility 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform Yes 2X No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence \bigcirc Other (Specify) Hospital: Son's 2 🔀 No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending Accident 2 No Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the Records, **Division of Vital** completed filled in by the

> State Registrar

3 🗖

M.

tim M Clark

Clark

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

recent

29b. Signature and title of certifier

Kristin

only one)

5018 Dorsey Hall Drive

carke

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D53966

29d. Date signed (Month. Day, Year)

Suite 104 Ellicott City, MD 21042

September 21, 2010

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 18^{ay} Frank Carroll Bowler 2010 9:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Morningside House Ellicott City Howard Social Security Number **Funeral** 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months 579-16-9955 Hours Min Country 88 1474/1921 Director DC Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director 1 ☐ Yes 2 🖁 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 27 is marked other than "natural", or items 23 traumatic event, the Medical Examiner must 10073 Century Drive 21042 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or <u>^</u> within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No 3 Widowed 4 □ Divorced If Yes, Give Specify. Specify: Completed White Year or Dates. 1942-45 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene, is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Installation Management Western Electric Be permit. Page 1 and 2 should be filed or Department of Health and Mental Hyg Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frank Carroll Bowler, Sr. Naomi Conway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol J. Hoskins - Daughter 10073 Century Drive Ellicott City, MD 21042 injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service Licensee any M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that haused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Year Day Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? 2 No 2 1 N 1 Yes Yes of Vital Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes 2 1 No Other: 욘 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 🗌 No ☐ Accident☐ Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature apd title of certifier way 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LO Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9 Mary F. Blair 18 2010 1:16 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1506 Ridge Road Catonsville Baltimore Social Security Numbe If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Days Hours Min. 7/22/1908 216-30-0696 Director 102 Usual Residence of Decedent 28a-f show 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 X No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1506 Ridge Road 21228 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed 3₺ Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Thomas Flynn Bridget Eileen Gary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 soft Health Joseph Blair, Jr. - Son Knox Avenue Reisterstown, MD 21136 20a. Method of Disposition
1

Maria Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s Department of H Important: If ite 9 New Cathedral Cem. 4 Donation 5 Other (Specify) 9/21/2010 Baltimore, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H. 21. Signature of Funeral Service Licensee Sum Col 4112 Old Columbia Pike Ellicott City, MD 21043 M01044 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ ong disease or condition Many weeks Medical resulting in death) Due to (or as a c sequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to jor as a consequence of cause. Enter Underlying physician and s the burial-transit requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year 1 Yes 2 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician: The law certificate has page 2 performed Yes 2 25. Was case referred to medical of Vital 船 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 No Other: ျှ ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

e Funeral Director: After the functed filled in by the function. Division 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Funer completed fil 29b. Signature and title of ompleted cause of death (Item 23a) (Type, Print) 05 the egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sep† 12 Day 20 Year Physician/ 4:47PM Stephen Leon Brooks Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Memorial Hospital Easton Talbot Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea 5 – 1.0 – 4.5 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days 1 □ M 2 □ F Hours Min. 65 Director 213-42-0630 MD Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits **Funeral Director** Yes 2 ,No 406 Moton St.Apt.203, Easton Maryland Talbot 10g. Citizen of What Country? 406 Moton St. Apt.203 21601 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates. Completed by 1 _Never Married 2 Married 1 Yes 2 No Specify: Black Specify 3 ☐Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Town of Easton Maintenance 10th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie Wilson <u>Stephen Brooks</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Thompson/Son Hillcrest Ave Sazisbury, Md. 21804 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 KBurial 2 Cremation 3 Removal from State 9-18-10 Trappe, Md. Ivytown Cem 4 ☐ Donation 5 ☐ Other (Specify) anure of Fune al Service Licensee 22. Name and Address of Facility 426 Dover St., Bennie Smith Funeral Home Easton, Md. 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner 12015 schemic Card say, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day 1 Yes 2 L 9 Unknown 2 No within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ infarchan myocardial 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an mothed obesite performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to edical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🗹 27, Manne of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu and title of cer 29d. Date signed (Month, Day, Year) D70405 cause o death (Item 23a) (Type, Print) 555 Cyndwood Avenue, Easton, Maryland 21601 31. Date filed (Month, Day, Year) State SEP 15 2010 Registrar

Stephen

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 #1 State
Registrar Certificate of Death pha 9/16/10 FH TCHD. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ **G**Month 13ay 20 TO NICHOLAS т. BARRY 1:52 $\mathbf{A}M$ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** TALBOT **EASTON** WILLIAM HILL MANOR Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Months Hours **|05//26/T9T9** 91 205-10-1478 PA **Director** Usual Residence of Decedent f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1**X** Yes 2 ☐ No MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 34 HUNTER COURT 21601 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc Completed by 1 Never Married 2 X Married Yes Yes, Give 2 🗆 1 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 Widowed 4 Divorced Year or Dates. 946 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) PETROLEUM MANAGER 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ BLANCHE WOLF NICHOLAS T. BARRY, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 34 HUNTER COURT, EASTON, MD JEAN E. BARRY / WIFE 21601 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🗶 Cremation 3 🗆 Removal from State CHESAPEAKE CREMATION 09/16/2010
CENTER STEVENSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lic FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final effusion RIT Probable Lun mets Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a construence of) ed by the attending physician and detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant a
9 Unknown Pregnant at time of death 5 Other (specify) 2 \square No 9 Unknown After this certificate has been signed by funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assist. Living ၉ 1 Inpatient 2 I ER/Outpatient 3 DOA in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1. Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) 9-13-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Easten, MD Krystel L Thomas 545 Cynwood Brive 15+VA 31. Date filed (Month, Day, Year) State SEP 15 2010 Registrar

DHMH 17 Rev 7/2009

10-07289					
Robert Brown					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert Brown		State of Maryland / Department of Health and Menta 1- For State Registrar Certificate of Death		Reg. No. 2011	30929					
Physicia Medical Examin		1. Decedent's Name (First, Middle, Last) Robert David Brown	2. Date of Dea Month Septembe	ath Day Year er 23, 2010	3. Time of Death 0851 hrs					
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Description of Example 2 Baltimore		4c. County of D	eath					
Funeral Director		5. Social Security Number 590-36 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Months Days Hours								
w any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
nyland 8a-f shov at once.	Director	Maryland Wicomico Pittsville 10e. Street and Number 10f. Zip Code	T	10g. Citizen of What (1 X Yes 2 No					
th the Ma 23a or 23 10tified	Dire	7329 Gumboro Road 21850		USA						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Port Properties If Yes, Specify: 1 No specify:	14. Race - Ar White, et							
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Ex iminer.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Sales person		16b. Kind of Busine	ss/Industry					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other tranmatic event, the Medic.	Be Con	17. Father's Name (First, Middle, Last)	Name (First, Middle,	Maiden Surname)						
ID 21; should be and Men 7 is mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number Proble Brown/mother 7329 Gumboro Rd.,	r or Rural Route Nur	mber, City or Town, S						
ore, M es l and 2 of Health If item 2 her traur	f	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City						
Baltime permit. Pag Department Important: injury or of	-	John Specify.)/27/2010	Salisbur						
の ^製 点 単語 Physician	+	21. Signature of Funeral Septice Licensee 22 Name and Address of Facility HOTIOWAY FUNERAL 501 Snow Hill Recommendations and Experimental Septice Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Computer Com	d., Salisl	bury, MD 2	Approximate Interval					
/Medic_l Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): benzodiazepine use	ine, and		Between Onset and Death					
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
ed ssit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):								
50, te be executed ysician and burial - transit	edical	AMENDED AMENDED, 27,28a-f,per ME g908 10.8/10) TT							
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the by the file of the funeral director.	Σί	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1		23d. Date of deliv Month	rery Day Year					
P.O. E that the connect by the detached	S P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to		to the cause of death?					
ords, I	leted		24a. Was autop	an 24b. Were	autopsy findings available to completion of cause of					
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the all price death. "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed	25. Was case referred to medical 26. Place of Death (Ch	perfor 1 ✓ Yes	rmed? death						
Physician r this cerr al directo	ě	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 No	ursing Home 5	Residence 6 Ot	her:					
ISION OF Attending Ph r death. ector: After t by the funeral		27. Manner of Death 1 Natural 5 Pending Investigation 28a. Date of Injury (Month, Day, Year) Fd 9/21/10 Fd 9:10 am 1 Yes 2 No	1 -	now injury occurred						
Division ospital or Attenchours after death hours after death nneral Director: y filled in by the	Certification:	3 Suicide 6 X Could not be determined (Specify) Multi-family apartment	28f. Location (S or Town, S Baltim	tate) 1041 St.	Rural Route Number, City Paul St					
To the Hospital within 24 hours To the Funeral completely filled	ا <u>ب</u>	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
F ≫ F 8	Me :	and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (#						
	-	30. Name and address of person who completed cause of death (Item 23a)		30010111061 24,						
Stat	e :	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21 31. Date filed (Mod Paragraphy 194) 2010 32. Jegistrar's Signature	201							
Registra	ar	SEP 28 2010 June D. Jules								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death BROWN Physician/ 2 800 VA 5 6 PT Medical 4a. Facility Name (if not institution, give street and number) 4b. Ott Town, or Location of Death 4c. County of Death **Examiner** DSPITAL ERU 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Hours Min Country)
Marvland 8/20/1958 **Director** 219-72-8490 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he marked once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No <u> Maryland | Washington</u> Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11 West Baltimore St. 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: 3 Divorced 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Construction Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Caroline Wilt Michael Francis Leona 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Sebald/ Sister 12376 Knollwood Dr. Waynesboro, Pennsylvania 17268 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Smithsburg Crematory 9/29/2010 Smithsburg Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, Maryland21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Yes 2 No g 🗆 Unknown r significant conditions contributing to death-but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 2 🗌 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No မ Inpatient 2 ER/Outpatient 3 DOA the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 125 Natural 5 Pending work? 2 🗌 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

3K

30. Name and address of person who completed cause of death (Item 23a) (Type, Brint)

32. Registrat's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 10:48 FM 0 1580 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) (State or Foreign Sex 1A M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 212-40-7279 Director MD 2/3/1943 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Example of the profiled at 1 □Yes 2 No Director MD Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10233 Red Lion Tavern Ct. 21042 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1. Ares 2 □ No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after deau Department of Health and Mental Hygiene. Important: If ten 27 is marked other the any injury or other trainment. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sal<u>esperson</u> Medical Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carroll Beckman C. Dolores Banz ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellicott City, MD 21042 Rita Beckman - Wife 10233 Red Lion Tayern Ct 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State Ardent Cremation 4 ☐ Donation 5 ☐ Other (Specify) 9/18/10 Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Furnir ervice Linea M01411 4112 Old Columbia Pike Ellicott City, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) MOCKEDIN /Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transi Exami Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d, Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 2 200 director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 24 No Certification: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 1 XNatural 5 Pending after death.

Director: Ald in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of cortifie 29c. License number 29d. Date signed (Month, Day, Year) Sep 0054484 16.

State Registra

Columbia, MD 21044

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5755 Cedar Lane

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Donald Berlin

31. Date filed (Month Da

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Edna Virginia Bittinger 5 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany WMHS Regional Medical Center Cumberland Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours OCT 18, 1919 1 🗆 M 2 😾 F Maryland Director 90 Yrs. 174-16-1153 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No MD Grantsville Garrett 10e. Street and Numbe ò 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 5893 Amish Rd. 21536 USA "natural", or item ledical Examiner n 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify Completed 3 😾 Widowed 4 🗆 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Mexicone. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward Hutzel Eda Ethel Durst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Newman/Grandson 97 Main St., Grantsville, MD 21536 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Grantsville Cemetery Sept. 24, 2010 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) e of Fune Service License 21. Signal 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or comp shock, or hear Hallure. List only or cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death e cause on each line Immediate Cause (Final Physician/ acu erebra 3 day disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Month Day 5 Other (specify) the 9 Unknown 9 Unknown After this certificate has been signed by a funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Aortic Se vere ste nosis † 🗆 Yes 2 🗆 No 3 🗆 Probably 4 📈 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital _2 🗷 No Other: မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 Natural 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical 1 Secritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) womock &h P0055325 2010

Registrar
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Camporland MD 21502

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

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WONSOCK

31. Date filed (Month, Day, Ye

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 19, 2010 Rhua Jean Beachy 4:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown Seasons Hospice of Northwest Hospital Birthplace (State or Foreign 8. Date of Birth . Age (In yrs. last birthday) Funeral Days 1 🗆 M 2 🕱 F Hours March Day Year) Maryland 68^{/rs} 1942 Director 166-34-7073 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20724 USA 339 Cokeland South Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give 3 K Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 8 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be filed and Mental H ပ Mary Ellen Sines Theodore Coddington permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20724 339 Cokeland South, Laurel, MD Michael E. Beachy/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State 2010 Davidsville, PA Country Side Crematory Sept. 22, 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licen 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician COL 6 mos disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: asn yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? ò Month Day Year Pregnant at time of death the 1 ☐ Yes 2T detached signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? has performe within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 2 ANo 2 No 1 Ves 25. Was case referred to medical Seasons 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 5 Other (Specify) 2 🔁 No Ho. Dice 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural work? 1 ☐ Yes 2 ☐ No 5 Pending М Accident Investigation Suicide 6 Could not be 3 ☐ Suicide4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 0105, Pl James 1737573 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Neels MB Swoth MD 2/209 Ю 31. Date filed (Monti 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Clinton Bayard Bollinger, Jr. Month Year Sept 2010 12:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dove House Hospice Westminster Carroll Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Director 219-22-8499 82 1/30/1928 MD. Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" مه نفصیت کورت میں اللہ 12 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carroll Hampstead MD 1 🗆 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21074 USA 1312 Summit Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married X Yes Baltimore, Maryland 21215-0036 1946 If Yes, Give 1 Yes 2 No Specify. white 3 Widowed 4 Divorced Year or Dates 1947 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore Gas & Elec. Appliance Sales 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clinton B. Bollinger, Sr. Lottie M. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1312 Summit Street, Hampstead, Md. 21074 Maude A. Bollinger, wife other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or St. Peter's Lutheran 9/16/2010 Millers, Md. 22. Name and Address of Facility Eline Funeral Home Signature of Funeral Service Licenses M00741 any emmer 934 S. Main St., Hampstead, Maryland 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. On at and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Due to (or a consequence of): Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) signed by the attending physician and de detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 2ka. Was an within 24 hours after death.

To the Funeral Director: After this certificate has page 2 s performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Dove Hour Other: မ 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at Hospice 28d. Describe how injury occurred iniury 1 Natural 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide npleted filled in by determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WIL 037949 IOTIVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) host wenter while

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

SEP

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23a,25 per me,g908,10/15/2010dhb
Registrar Registrar Registrar Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1:39 am AUDREY CLARISSA THOMAS BARNES pentembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medical Civista a Plata narles If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👽 F Months Davs Hours NOVEMBER 13, 1943 MARYLAND 66 213-46-8007 Yrs Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director LA PLATA 1 X Yes 2 No **CHARLES** MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 20646 101 WESLEY DRIVE #217 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give δ 1 Never Married 2 Married 21215-0036 hours after 1 ☐ Yes 2 XNo Specify: Specify: BLACK Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEKEEPER HOUSEKEEPING COOK 12TH GRADE is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ CATHERINE WILLS THOMAS GOLDRING LEMUEL JARRETT THOMAS injury or other traumatic permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10427 HANOVER CHURCH ROAD, KING GEORGE, VIRGINIA 22485 THOMAS C. BARNES, JR. SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ABurial 2 Cremation 3 Removal from State MARYLAND VETERANS CEMETERY SEPT. 21,2010 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Structure of Funeral Services LyDIA C. THORNTON JOHNSON MO0583 THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

To the Funeral Director. After this certificate has been signed by the attending physician and Hypertension Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury CERTIFICATION APPROVED BY MEDICAL EXAMINER that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Other (specify) 4 ☐ Pregnant a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner?

1 X Yes 2 æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient 2 27. Manner of De 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature

State

DHMH 17 Rev 7/2009

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Registrar

31. Date filed (Month, Day,

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e Road; Suite 101 Waldorf, M

of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Sept 10,2010 10:15pm^M Osborn S. Belt Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs 5. Social Security Numbe 8. Date of Birth 1 (1/4-(1/19)-19-2)1 9. Birthplace (State or Foreign **Funeral** 578-40-8144 1 XM 2 - F 88 Hours Min Washington DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f sho must be notified at Director 1 x Yes 2 □ No Chevy Chase Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral United States 20815 7021 Meadow Lane 12. Was Decedent Ever in U.S. Armed Forces? 11-1942 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner r 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 09-1945 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Law Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bertha Brownell Rigel Osborn Belt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7021 Meadow Lane, Chevy Chase, MD 20815 Katherine Medlock Belt / Wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Triangle, VA Ouantico National Cem 9-15-10 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons, INC Wi 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anoxic Encephalopathy Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Ishemic Cardiomyopathy Sequentially list conditions, Examine Due to (or as a consequence of) cause. Enter Underlying Cornary Artery Disease Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Sbokn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Pulmonary Fibrosis, Chronic Renal Insuffuciency 1 Yes 2 No 3 Probably 4 Unknown Recorás, Completed 24b. Were autopsy findings available prior to completion of cause of death? Artrial Fibrilation 24a. Was an autopsy performed? Yes 2 No this certificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes 2 🖁 No Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Certificate: To 1 XInpatient 2 ER/Outpatient 3 DOA Menner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After t iniury Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) molle 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Debought J. Barbown W.D. 57/54 W. SCONSIN

Registrar

31. Date filed (Month, Day, Year)

1 6 2010

2. Registrar's Sign

30937

			Registrar		Cei	rtifica	te of Deatr	7	Re	eg. No.			
	Dhamisis	/	1. Decedent's Name (First, Middle, La						Date of Death Month		Vear	3. Time of Death	
	Physicia Medic			Iiries Banda	li Barba	ri_			Septembe	er 10	, 2010	11:50p M	
- 4	Examir		4a. Facility Name (if not institution, giv	e street and number)		4b. Cit	y, Town, or Locatio	on of Death		4c. Co	unty of Death		
-				s Hospital			Silver		3		Mont	gomery	
	Funeral			Sex 7. Age (In	yrs. last birthday)	If Und Months			8. Date of Birth	Year)	9. Birthp	place (State or Foreign	
	Director		212-64-0821	I ALIWIZLIF	86 Yrs.				July 27	,1924	4 Pa	lestine	
	d ow it	_	Usual Residence of Decedent 10a, State 10b, County	10	c. City, Town or Lo	cation					1	0d. Inside City Limits	
	rylan -f sh ied a	용			ic. Oity, Town of Le	Cation	0'0					1 ☐ Yes 2 🔯 No	
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	th th	le.				101. 2	ip Code		1	0g. Citizen	of What Coun	-	
	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	12020 Clari		· · · · · Lia	41 5	209		Y Man and Ma		u.s.		
	dea r ite	표	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	was Dece If Yes, spe	edent of Hispanic (ecify Cuban, Mexic	origin? (Speci can, Puerto Ri	ity yes or No- ican, etc.)		Race - Americ Black, White, e		
36	after Il", o xam	d by	1 ☐ Never Married 2 🕱 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 X No		1 🗌 Yes	2 X No Spec	ify:		Spe	ecify:	White	
Ş	ours ature	Completed	15. Decedent's	Year or Dates.	16a Dece	dent'e He	ual Occupation			10-10-1	of Designation		
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p	led within Hygiene. other tha	Be	17. Father's Name (First, Middle, Last)						(First, Middle, M	-			
an	be fi ental ked ic ev	욘	Bandali Saliba Barbari Olom								al.		
Maryland 21215-0036	should be file and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Relationship (na Addre	ss (Street and Nun	nher or Rural I				Code)	
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ē,	Hearlifern other		20a. Method of Disposition	2	20b. Place of Dispo	sition (Na	ame of				ion - City or To		
Himore,	perfiit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show among injury or other traumatic event, the Medical Examiner must be notified at once.		1 🛛 Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spee	Removal from State	Gate of			00/11	5/2010	Silva	+ Snri	aa MD	
到	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Ucer									Home. Inc.	
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		_	23a. Part 1. Enter the disease, or con	plications that caused the							i Oproch	Approximate	
	DI		shock, or heart failure. List only Immediate Cause (Final									Interval Between Onset and Death	
-	Physician/ Medical		disease or condition resulting in death)	a. Sepsis Due to (or as a co	200010000000000000000000000000000000000								
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68760	certificate be executed nding physician and use as the burial-transi	n/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p	regnancy					234	. Date of delive	20/	
		cial	in the past 12 months?	1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3 L ne of death 5 [□ Ectopic □ Other (state)	pregnancy specify)			200	Month	Day Year	
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P.0.	de de		Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying	cause given in Pa	art I.	23e. Did tob	acco use o	contribute to th	e cause of death?	
	sign d be	Completed by							1 🗆 Ye	s 2 🗆 N	No 3 🗆 Prot	oably 4 🛭 Unknown	
rd	The law requires ate has been sign page 2 should be	ete							24a. Was an	1 2	4h Were autor	osy findings available	
20	The law cate has I page 2 s	교							autopsy	v	prior to con death?	npletion of cause of	
of Vital Records,	sician: The certificate rector, pag		or we will be to	Τ					1 🗌 Yes 2	X No	1 Yes	2 No	
ta	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	eath (Check o	, , ,								
fΝ	Phys this al di	2	1 Yes 2 X No 27. Manner of Death	Hospital: 1 1 Inpatient 28a. Date of injury	2 ER/Outpatie				e 5 Resider)	
0 L	ding F h. After funer	ate	1 🗓 Natural 5 ☐ Pending	(Month, Day, Ye			28c. Injury at work?	_	3d. Describe hov	w injury oc	curred		
Division	r Attending er death. ector: After by the fune	Certificate:	2 Accident Investigation 3 Suicide 6 Could not	26	At home for	M 1 Yes 2 No							
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To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th Completed filled in by the funeral

Medical

3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kanwaljit Kaur Nagi, MD, 1500 Forest Glen Road, Silver Spring, Maryland 20910

20056063

State Registrar 31. Date filed (Month, Day, Year) SEP 1 6 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	of Maryla				lealth and N	/lental Hy	giene		
			Registrar			Ce	ertificat	e of L	Death		Reg. No. 2	10	30938
Ph	ysicia	n	1. Decedent's Name (First, Middle, L	.ast)						2. Date of De Month	Day	Year	3. Time of Death
	ledica		Lauretta 4a. Facility Name (If not institution, g	in atreat and a	Butt	S	41: 07:	T	Landing of Doods	SEPTEM		2010	5:45P.M.
Ex	amine	er	Reeders Memoria		#IIDel)				Location of Death		4c. County		
Fun	eral			Sex	7. Age (In yr	rs. last birthday			If Under 24 Hrs.	8. Date of Bir (Month, Da	Washi	9. Birthp	lace (State or Foreign
Dire	_		220-18-1014	1 □ M 2 🂢 F	96	Yrs.	Months	Days	Hours Min.	June 3		Coun Ma	ryland
pu »			Usual Residence of Decedent										
laryla	H N	5	10a. State 10b. County			City, Town or L						11	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
The Maryland	暑	ect	Maryland Washin;	gton		Boonsb	0 r 0 10f. Zip	Codo			10g. Citizen of W	(h = 1 C = 1 = 1	**
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LALL RETTA 5-0036 72 hours after death with the Maryland natural", or items 23a or 28a-f show	mer must be	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.	. Was Deced	ent of Hi	ispanic Origin? (Sp	ecify Yes or No	U.S.A.	e - Americ	an Indian,
16 after dea or items			1 ☐ Never Married 2 ☐ Married	Armed Fo	2 X No				ın, Mexican, Puerto	Rican, etc.)		k, White, e	etc.
1. All K 6 5-0036 72 hours after "natural", or i	Eva .	ğ	3 Widowed 4 □ Divorced	If Yes, G Year or D	oates:		1 □ Yes 2	5 ¥ 1100	Specify:		Specify.	Wh	ite
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121 within ene.		g (Elementary/Secondary (0-12)	College (1-4or 5+))		3.7		
Thygi Hygi	ent, t		17. Father's Name (First, Middle, Las	st)		House	<u>ekeepi</u>	ng	18. Mother's Name	e (First, Middle,		ing l	dome
Maryland Maryland d 2 should be file tith and Mental Hy 27 is marked oth	tic ev	lo Be	George Markwood	Itnyre					Elizab	eth Ann	Turpin	,	
lary shou	auma		19a. Informant's Name/Relationship	(Type. Print)		19b. Mail	ing Address	(Street a	and Number or Rur	al Route Numb	er, City or Town,	State, Zip	Code)
and and and a n 27	ler tra		Dorothy C. Alexa	ander/Da					nue Hage	rstown,	Marylan	đ 2	1742
Ore ges 1 t of H If iten	to 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐ Removal from	20b.	. Place of Disp cemetery, cre	osition (Nan ematory or o	ne of ther place	e)	Date	20c. Location -	City or To	wn, State
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Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If them 27 is marked other than "	any fr once.		21. Signature of Funeral Sovice Lice	D. 200	al .				ss of Facility Bas ational l				Home, PA 21713
			23a. Part 1. 7 ter the disease, or conshool or heart failure. List onl	mplications that of your one cause on e	ca sed the dea	ath. Do not er				A			Approximate Interval Between
Physic /Medi			Immediate Cause (Final disease or condition resulting in death)	a. prol	ulili	cereline	, No	Mu	lor acc	eilens	A		Onset and Death
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Box 6; eath certific	Se as	/Me	IF FEMALE:	23c. If yes, ou	teams of progr	nancy							
Box eath cer		Pnysician/me	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2☐Fe nant at time of	tal death 3	☐ Ectopic p		1		23d. Date Mor	e of delive oth	ry Day Year
ds, P.O. I	Da l	38	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unkr		death 5	□ Other (sp						
S that I		ý	Part II. Other significant conditions	contributing to d	eath but not re	esulting in the	underlying ca	use give	en in Part I.	23e. Did te	obacco use contr	ibute to th	e cause of death?
of Vital Records, P.O. Box (Physician: The law requires that the death certificate has been signed by the attending										101	Yes 2 No	3 ☐ Prob	ably 4 🗆 Unknown
Reccelaw re		palaidilloo			_					24a. Was		Vere autor	osy findings available
The The	ector, page	5								autor perfo 1 □ Yes	rmed? d	eath?	npletion of cause of 2 \square No
of Vital F Physician: Th	, con		25. Was case referred to medical examiner?						26. Place of Deatl				
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isten deat	S S	2	2 Accident investigation 3 Suicide 6 Could not	20	of Injury - At I	home farm st			/es 2□No	28f Location /	Street and Number	r or Pum	I Pouto Number
Div			4 ☐ Homicide determined	buildi	ng, etc. (Spec	home, farm, st c <i>ify)</i>	oot, tablery,	omoo		City or Tov	Street and Numbe vn, State)	ii Oi nurai	noute Number,
To the Hospital of within 24 hours of To the Funeral D	Modical ma		29a. Certifier (Check only one) Certifying F	ı miner: On the b	best of my kreasis of examir	nowledge, dea nation and/or i	th occurred nvestigation,	at the tim	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and ma date and place, a	nner as st	ated. the cause(s)
To the vithin To the	Mo	<u> </u>	29b. Signature and title of certifier	und man	ciatou.		29c	License	number		29d. Date signed	(Month, L	Day, Year)
A NE			· RU				0	32	CIC		0/2.1.		
2		-	30. Name and address of person who	completed caus	se of death (Ite	em 23a) (Type,		100	-3/5		7/20/10	,	
9			DR. ROBERT GUEDE					SVIL	LE, MARY	LAND 21	756 301	-432	-2222
Red	State istrar		SEP 2	2010 32.	egistrar's Sigr	nature	and	,					

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

the

29c. License number

29d. Date signed (Month, Day, Year)

Walsh Rd Cumberland MD

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 30940 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Year September Joseph Lloyd Bowen, Jr. 12:05 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In vrs. last birthday Days Months 220-26-4627 82 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 □ No Maryland Calvert St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2855 Lloyd Bowen Road 20685 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XX es 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 □Yes 2 🛛 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lineman Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) J. Lloyd Bowen, Sr. Elizabeth Hardestv 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Bowen / Wife 2855 Lloyd Bowen Rd., St. Leonard, Maryland 20685 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Waters Memorial 09/21/2010 St. Leonard, Maryland 22. Name and Address of Facility Rausch Funeral Home, PA. 21. Signature of Funeral Service Licenses Kyle S. Simons MO1206 4405 Broomes Island Road, Port Republic, Maryland 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Myo cardial infaction Due to (or as a consequence o): Carchio vosculor disease Atherosclerent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pulmonary Edema 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Advance 2 ⊡No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Vo 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriant-transit P.O. Box 68760, Division of Vital Records,

Physician/Medical

Completed

Be

Certification:

cal

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evarunas must be notified as any injury or other traumatic event, the Medical Evarunas must be notified as any injury or other traumatic event, the Medical Evarunas must be notified as any injury or other traumatic event, the Medical Evarunas must be notified.

Physician

/Medical

Baltimore, Maryland 21215-0036

dRW 8+1

State Registrar 29b. Signature and title of certifier gan . C. Surana 29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

D-50653

1 ☐ Yes 2 ☐ No

9-17-2010

5851 Deale Churchton Road

GYAN C. SURANA Deale

31. Date filed (Month, Day, Year) 32. Registrar's Signature

5 Pending investigation

6 ☐ Could not be

2010 Barke

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Maryland State of Maryland		irtment of F tificate of D			giene Reg. No. 20	10	30941
Physic	ian/	Decedent's Name (First, Middle, Last)				2. Date of De	ath	Year_	3. Time of Death
Med Exam	ical	Mary L. Campbell 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death		ber 3,	2010 y of Death	10:59 P _M
) LXdiii		Woodward Estates		Bowie			Prince George's		
Funera Directo		5. Social Security Number 6. Sex 7. Age (<i>In yrs. la</i>	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month Da June 10	th y, Year) 1928	g. Birthpl Count Virgi	ace (State or Foreign ry) nia
nd how at	'n	Usual Residence of Decedent	, Town or Loc	ation					Od. Inside City Limits
Maryla 28a-fs etified	recto	Maryland Prince George's Bowi	ie						1 X Yes 2 □ No
th the I 3a or 2 1 be no	al Di	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Count	ry?
eath wi ems 2 ir mus	Funeral Director	1100 Pennypacker Lane 11. Marital Status 12. Was Decedent Ever in U.S	. 13. W	20716 /as Decedent of His	spanic Origin? (Sp	ecify Yes or No-	USA lo- 14. Race - American Indian,		
after de	ğ	1 X Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ☐ X No If Yes, Give		Yes, specify Cubar ☐ Yes 2 ☐ No		Rican, etc.)		ick, White, e	tc.
2-0030 2 hours after "natural", o	letec	3 Wildowed 4 Divorced Year or Dates. 15. Decedent's Education	16a. Deced	ent's Usual Occupa	ation		16b. Kind of I	พทาง	
hin 72 ne. than "ı	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	life. DC	ind of work done d NOT use retired)	0	king			
ld / I	Be	12 17. Father's Name (First, Middle, Lest)	Foreig	gn Servic	18. Mother's Nan	ne (First, Middle,	State Maiden Surnan		ment
Dealtill Of e.) Mid ylail of ZIZIO-0000 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once.	2	Lewis Campbell			Frances	Colvin			
IVICATION INTO INTO INTO INTO INTO INTO INTO		19a. Informant's Name/Relationship (Type, Print) Thelma C. Larson/ Sister	T i	g Address (Street a Pennypac			-	State, Zip Ci 716	ode)
e 1 and of Hea		20a, Method of Disposition 20b, Pl	ace of Dispos	sition (Name of		Date	20c. Location		vn, State
DallIIIIOI Demit. Page 1 Department of mportant; If it any injury or o		Men	nortal	atory or other place nont Gardens	! 9/0/	2010	Davids		
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⊸Pnysician. ⊱ Medica	_	Immediate Cause (Final disease or condition resulting in death) Alzheimer's Due to (or as a consequence)		se				-	Onset and Death
Examine		Sequentially list conditions.							
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The law cate has be page 2 s	Completed					24a. Was autor perfo	osy rmed?		sy findings available apletion of cause of
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eath. or: After th	27. Manner of Death 1 X Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 1 Pending 2 Accident 3 Suicide 6 Could not be determined 4 Homicide determined 28b. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28b. Time of injury at work? 1 Pending 28b. Location (Street and Number or Rural Route Num 28b. Date of Injury - At home, farm, street, factory, office 28b. Date of Injury - At home, farm, street, factory, office 28b. Date of Injury at work? 1 Pending 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 28b. Date of Injury at work? 2b. Da								
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To the Parithin 2 To the Foomple	Me	only one) 3			time, date and pla	ce, and due to th		nanner as sta	ted.
F > F 0) Jan		D26190)			5/20	
420		30. Name and address of person who completed cause of death (Item David L. Siegel, M.D. 14999 Hea			ive Rowie	. MD 20	716		
Sta		31. Date filed (Month, Day, Year) SEP 1 6 2010 32. Registrar's Signature			70 201110	., IID EU	. 10		
Regist	rar	JEL TO TOIL PARAME	14. 14	64.64 A.					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 30942 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9 Year BETTY J. CUMMINGS 931 OIL Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death E ASTON TALBOT MEMURIAL Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **OHIO** Funeral 7. Age (In yrs. last birthday) 1 □ M 2 🗶 F Days 79 292-26-4283 11/20/1930 Director Yrs. Usual Residence of Decedent 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** MD 1 X Yes 2 No TALBOT TILGHMAN ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a 21476 GIBSONTOWN ROAD UNITED STATES 21671 12. Was Decedent Ever in U.S. Armed Forces? 1

Yes 2 □ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 X Married Specify: WHITE 1 ☐ Yes 2 X No Specify. 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If fem 27 is marked other than "ns
any injury or other traumatic event". (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ CLOYD BOOP ANNA MANN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK A. CUMMINGS / 5421 ANCHOR RD., TILGHMAN, MD 21671 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MISSION ROAD other place) 4 Donation 5 Other (Specify) 09/20/2010 TILGHMAN, MD Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final RESTRICTIVE LUNG Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** OBSTRUCTIVE LUNG Secure dielly list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? Yes 2 No 2 🗹 No 1 Tyes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 ☐ No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury_at 28d. Describe how injury occurred 1 Matural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State

olu Bolses

JOHN BOTSIS, MD

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

219 S. WASHINGTON ST., EASTON, MD

00059487

21601

9-14-10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 311943 State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gary Oliver Charsha September 2010 2210 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 42 Peacock Lane Port Deposit Cecil Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday) 8. Date of Birth **Funeral** Country) Maryland Months Hours Min. (Month, Day, Year) 217-50-0738 Director 61 Feb. Usual Residence of Decedent or 28a-f shov notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🎾 No Cecil Port Deposit Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe Funeral 21904 42 Peacock Lane U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 2**X** No ☐ Yes aryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes. Give 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 6b. Kind of Business Industry Wileys Mfg. Company (Specify only highest grade completed) Elementary/Seconday (0-12)
Twelve Years College (1-4 or 5+) other traumatic event, the Port Deposit, Maryland Rigger Be 18. Mother's Name (First, Middle, Maiden Surname)
Louella P. Tibbs 17. Father's Name (First, Middle, Last) Joseph O. Charsha 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)
Linda P. Charsha (wife) 42 Peacock Lane, Port Deposit, Maryland Baltimore, Important: If item any injury or other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date West Chester. 1 Burial 2 D Cremation 3 Removal from State R.A.Ferris & Co., Inc. 09/23/10 Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one caus, on each line. Immediate Cause (Final Onset and Death Physician/ rost disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician; The law within 24 hours after death.

To the Funeral Director: After this certificate has t autopsy performed? 1 ☐ Yes 2 XNo director, | Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29d. Date signed (Month, Day, Year) State Registrar

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Division	그 를 타고	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □ Could i determ	not be	28e. Place build	of injury ing, etc. (- At ho Specify	me, farm,	street, fac				28f. Locati City o	on (Stree r Town, S	et and Nur State)	mber or Run	al Route N	umber,
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State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Tipaporn Woodward, MD 7830 Old Georgetown Rd. #C15, Bethesda, MD 20814

29c. License number

D17656

29d. Date signed (Month, Day, Year)

9/10/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				Pepartment of Health and Menta Certificate of Death	al Hygiene 0 1 0 3 0 9 4 5
	Obvoisi		Decedent's Name (First, Middle, Last)		ite of Death 3. Time of Death
	Physici /Medi		Kosa Calcagno		P 14 2010 9:10 PM
	Examir	er	4a. Facility Name (If not institution, gud street and number)	4b. City, Town, or Location of Death	4c. County of Death
			608 Curry Ford LN.	Gathers buy	Montgomery
	Funeral Director		5. Social Security Number 235-70-4167 Usual Residence of Decedent 6. Sex 1 M 2 M F 7. Age (In yrs. last birt.) 69	Months Days Hours Min. (M	te of Birth onth, Day, Year) 12, 1941 9. Birthplace (State or Foreign Country) 1 taly
	land ow		10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
	be filed within 72 hours after death with the Maryland tal hygiene. d other than "natural", or items 23a or 28a-1 show avent, the Medical Exercities cust be rediffied at	ţō	W.V. Ohio Whee	eling	1 X Yes 2 □ No
	r 288	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	h witi		36 Pleasant Dr.	26003	United States
	dear dear	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yell If Yes, specify Cuban, Mexican, Puerto Rican,	es or No- 14. Race - American Indian,
98	or h	/Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ☒ No Specify:	
8	hours ural',	d by	3 ☐ Wildowed 4 [X] Divorced Year or Dates:		Specify: White
7	"nat	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
12	withi iene. than	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	eamstress	Tailor/Own Business
b	filled I Hygi other	Be C	17. Father's Name (First, Middle, Last)		, Middle, Maiden Sumame)
Baltimore, Maryland 21215-0036		To B	Gaetano Donzella	Maria Sponz	iello
ary	and and sm			Mailing Address (Street and Number or Rural Route	e Number, City or Town, State, Zip Code)
Σ.	ss 1 and 2 of Health item 27 I			Curry Ford Ln., Gaithe	ersburg, MD 20878
ore		1	1 V Rurial 2 Compation 2 VI Removal from State cemeter)	Disposition (Name of , crematory or other place)	20c. Location - City or Town, State
Ë	Pag tment tant: jury		`4 Donation 5 Other (Specify)	Calvary ry 9/18/2010	Wheeling, WV
Ba	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee M00956	Altmeyer Funeral Home 1400 Eoff St. Wheeling	
			23a. Fart1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.		
	Physician i		Immediate Cause (Final disease or condition	Veolar lung Cance	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of		, ,
	Examiner	_	Sequentially list conditions, b.		
	A EA	Examiner	it any, les and to immediate Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury	f)s	
	and and li-trar	хап	that initiated events resulting in death) Last C. Due to (or as a consequence of	n:	
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical E			
687	tificate ng phy: as the	edic	ā.		
Box	eath certif attending for use as	NA.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	-5-	23d. Date of delivery
		Physician/Med	in the past 12 months? 1 ☐ Yes 2 No	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	Month Day Year
P.O.	the ache	hys	9 Unknown		
		by F	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	Se. Did tobacco use contribute to the cause of death?
Records,	requires een sign hould be	Completed by	# (news vero 112 (or ending # 12 mg D) Coase	1 Diabotas vellitis ype	1 Probably 4 Unknown
ec		nple	Hyperthyroidism High Blood fre	55 W.R. 24	a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
	ale pag		Colostomy Status-Post ruptureddiv	inticulum operation (Jan 2019) 10	performed? death? Yes 2 No 1 Yes 2 No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referr to medical examiner? Hospital: Hospital:	26. Place of Death Chec	
of	S .5 .5	7	1 Inpatient 2 ER/Out		X Residence 6 □ Other (Specify) secribe how injury occurred
on	ding I th. After funer	tlon		me of 28c. Injury at 28d. De jury Work? M 1 ☐ Yes 2 ☐ No	sacribe now injury occurred
Division	or Attending after death. Director: After in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fan	m, street, factory, office 28f. Lo	cation (Street and Number or Rural Route Number,
Ö	safter safter of Direct	Certification;	4 Homicide determined building, etc. (Specify)	Cit	ry or Town, State)
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical (29a. Certifier (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Ch	death occurred at the time, date and place, and du	e to the cause(s) and manner as stated.
	To the H within 24 To the F complete	ledi	and manner stated.		
	with the second	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
į	t		Michael Frett 118	Maryland ()0066	113 September 15, 2010
		-	30. Name and address of person who completed cause of deal (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 23a) (Item 2	Type Print) Rove Ed. Locallo	MD 20850
	- Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Jose Fy. Pocevine	
1	Registr		SEP 1 7 2010 Sender S. 190	white.	

Teresa Michelle Carpenter

Pleas

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se Type or Print in Black Indelible Ink. Ensure All Copies Are Legik State of Maryland / Department of Health and Mental Hygiene	201	U	30946

		1- For State Registrar Certifi	icate of	Death	ia montan	Ren	J. No.	00740
Physicia		Decedent's Name (First, Middle,Last)				2. Date of Death		3. Time of Death
Medical Exami	ner	reced menetie carpencer				Month September	20, 2010	1644 hrs
		Facility Name (if not institution, give street and number) 13921 Village Mill Drive #2	46	o. City, Town, o Maugansvi	or Location of Deat	th	4c. County of Death Washington	
Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last t	birthday)	If Under 1 Ye		e Is Date of Birth	(MM/DD/YYYY) 9. Bir	thniago (State as
Director				Months Da		n.	Foreig	gn
		214-92-8273	Yrs.			August	16,1964 94	aryland
any			wn or Location	n				10d. Inside City Limits
bow Et	ŗ.	Maryland Washington		Maugans	zvillo			1 X Yes 2 No
arylai 8a-f	cto	10e. Street and Number		10f. Zip Code	24116	10g	. Citizen of What Cour	ntrv?
the M	Director	13921 Village Mill Drive No. 2	1	21	L767		US	λ
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	eral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was	Decedent of Hi	ispanic Origin? (S	pecify Yes or No-		can Indian, Black,
death rr iter	5	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes	s, specify Cuba	in, Mexican, Puerto	o Rican, etc.)	White, etc.	
after al", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Y	res 2XX No	o s <i>pecify:</i>		Specify:	White
hours natur	ed t	15. Decedent's Education (Specify only highest grade completed) 16a	a. Decedent's	Usual Occupa	ation (Give kind of e. DO NOT use ret	work done 1	6b. Kind of Business/I	ndustry
36 in 72 in 12 lical 1	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	g	_				_
with spiene	шо	17. Father's Name (First, Middle, Last)		Splic		(F) (M) ()	Film Deve	loping
115- e filed al Hy ted of	Be C	Terry M.S. Butts				e (First, Middle, Ma en Ann Sti		
212 uld be Ment mark	To B		19b. Mailing A	Address (Stre			er, City or Town, State,	Zin Code\
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.							town, Mary	
e, Pand I and Healti		20a. Method of Disposition 20b. Place	e of Disposition	on (Name of ce	emetery,	Date 2	20c. Location - City or	Town, State
nor ages at 1 If If If If		The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	atory or other		, , ,			
nit. P nit. P artme sortan		4 Donation 5 Other Specify Green 1. Signature of Fundervice Updansee	niawn 1	Mem. Pa	nrk sept Meral Ho	24,2010	Williamspo	ort,Marylan
Balt permit Depart Impor injury	1						illiamenor	t, MD 21795
Physician	\exists	23a. Part I. Effer the disease, or complications that caused the death. Do failure. List only one cause on each line.	not enter the	mode of dying,	, such as cardiac of	or respiratory arrest	, shock, or heart	Approximate Interval
/M i Examiner	ı	Immediate Cause (Final disease a. Hypertensive at	herosc	lerotio	c cardiov	vascular	disease	Between Onset and Death
Bxammer		or condition resulting in death) Due to (or as a consequence of):						
		Sequentially list conditions, b						
	į	if any, leading to immediate Due to (or as a consequence of): causes. Enter Underlying Cause						
_ =	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
760, cate be executed physician and the burial - transi		d						
760, cate be execut physician and he burial - tra	Medical	X UNPENDED AMENDED 23a,PII,27,p	er ME	g908 10	0.8.10 T	Γ		
		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnance 1 Live birth	;y 				23d. Date of delivery	
Box 68 death certifi he attending of for use as	cial	past 12 months? 4 Pregnant at time of death	_ =	death 3 (· (Specify)	Ectopic pregna	incy	Month D	ay Year
BO) e death the att	Physician	1 Yes 2 No 9 V Unknown 9 Unknown	U Other	(Opecity)				
P.O. Box 68 ss that the death certif gned by the attending the detached for use as		Part II. Other significant conditions contributing to death but not resulting	ing in the und	erlying cause g	given in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
ords, P.C w requires that us been signed 1 should be deta	Completed by	Diabetes mellitus				1 Yes	2 No 3 Proba	ably 4 🗸 Unknown
v requ	ete					24a. Was an autopsy		opsy findings available impletion of cause of
ecc he lar ate ha	Ē					performe		
tal Rection: The certificate ector, page	انه	25. Was case referred to medical		26.Place	of Death (Check		1 7 763	2 140
Vita	0	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/C	Outpatient 3		Other		sidence 6 🗸 Other:	Scene
n of Vi	2		. Time of Injur	ry 28c. Injur	ry at Work?	28d. Describe how	injury occurred	
ion ttendi leath. for:	읉	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation		1 Y	res 2 No			
Division of Vital Records, pital or attending Physician; The law requir ours after death, retail Director: After this certificate has been similar in by the funeral director, page 2 should be.	<u></u>	3 Suicide 6 Could not be 28e. Place of Injury - At home, 1	farm, street, f	actory, office b	uilding, etc.		et and Number or Rura	al Route Number, City
1 E & & E	Certification:	4 Homicide determined (Specify)				or Town, State	') 	
To the Hos within 24 h To the Fun	ल	29a. Certifier (Check only One) Certifying Physician: To the best of my knowledge, de One) A Medical Examiner: On the basis of examination and/on	eath occurred	at the time, da	ite and place, and	due to the cause(s)) and manner as stated	i.
To tl Comp	g E	one) 2 Medical Examiner: On the basis of examination and/or and manner stated. 29b. Signature and title of certifier	investigation					
	۱	290. Signature and title of certifier		29c. License			9d. Date signed (Mont	
	L	wood Hallan		O.C.N	VI. E.		September 21, 20	10
		 Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 		eet Baltimo	ore, MD 21201	1		
Sta	te :			- Daimine	5.0, IND 2 120			
Registra	ar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	has	S.				
DHMH 17 Rev 1/200)1	OCME OF	RIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30947 = State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year GLORIA ANN CARACCIOLO 2.40 Medical September 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗙 F Months Days Hours Min 62 1948 **Director** 218-54-7654 Sep Virginia Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Martin and injury or other traumatic event. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Completed by Funeral Director Maryland Frederick Thurmont 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Sandy Spring Ct #3 21788 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) Food Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Addison Smith, Jr. Gloria Summers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cyndi Gill, daughter 1170 16th Avenue, Clarkson, WA 99403 20a. Method of Disposition 20b. Place of Disposition (Name of Crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State Carroll Crematory 9/14/2010 Winfield, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727 Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line 23a. Part 1/ enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betweer Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Day Pregnant at time of death 5 Other (specify) Month ate has been signed by the a page 2 should be detached 9 \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ▶ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 24 hours after death.

Funeral Director: After this certificate has be autopsy Yes 2 N Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ၉ 2 No XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) upleted filled in by the funeral 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work?
1 \(\sum \) Yes 2 \(\sum \) No 5 Pending ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4. Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the F only one To the 29b. Signature title of certifie 29d. Date signed (Month, Day, Year) MJL

Registrar DHMH 17 Rev 7/2009

State

3

cause of death (Item 23a) (Type

Redistrar's Signature

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 30948 State of Maryland / Department of Health and Mental Hygiene 2010 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Month}ep 19, 2010 Conley Warren 5:20 George Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11606 Birch Avenue Cumberland Allegany 5. Social Security Number 9. Birthplace (State or Foreign Country) WV 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 1 € M 2 🗆 F Hours Apr 2, 235-20-9340 Director 85 Usual Residence of Decedent shov 10b. County be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ?7 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified 1 XYes 2 No MD Allegany Cumberland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 11606 Birch Avenue 21502 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Boilermakers Local 154 Pipefitter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Ment Important: If Item 27 is market any Injury or others. George Conley. Mary Ann (LeMasters) Conley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Penny Penrod</u> <u>Cumberland</u> MD 21502 Daughter <u>11606 Birch Avenue</u> 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 9/22/2010 Rocky Gap Veterans Cemetery MD Flintstone 21. Signature of Funeral Service Licensee 22. Nam Scarbelli Fufferal Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ARDIOMYGRETH disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury Dus to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1. Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner. On the basis of examination and support of the cause (s) and manner as stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certi 200 ZOX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12502 Willowbrook Rd Suite 450 Cumberland MD Robert Welik 31. Date filed (Month, Day, Year) 32. Registra s Signature State 4 2010 Registrar

10-07352 William Clark Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

William Clark		State of Maryland / Department of Health and Mental Hygie 1- For State Registrar Certificate of Death	7111	0 3091
Physicia		1. Decedent's Name (First, Middle,Last)	Reg. No.	3. Time of Death
Medical Examin	ner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	eptember 24, 2010	1908 hrs
		Peninsula Regional Medical Center Salisbury	Wicomico	
Funeral Director		Months Davis Haura Min	Date of Birth(MM/DD/YYYY) 9. Bi	ign
		Usual Residence of Decedent	3-13-1956	ountry) MD
ow any		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
aryland 8a-f sho	Director	VA Accomack Atlantic 10e. Street and Number 10f. Zip Code	10g. Citizen of What Cou	1 Yes 2 No
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ath with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Never Married 2 Married Forces? If Yes, specify Cuban, Mexican, Puerto Rican		rican Indian, Black,
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21215-0036 21215-0036 2215 build be filed within 7 I Mental Hygiene. marked other than ic event, the Medica	Be Co		, Middle, Maiden Surname)	
212 ould be d Ments s mark	To B		a Shield's Route Number, City or Town, State	e, Zip Code) 2233/a
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Valerie Merritt / Daughter Vacation Park 20a. Method of Disposition (Name of cemetery.) Date	Lanz Chincote	agu VA
nore ages 1 g nt of Hit		1 Burial 2 Cremation 3 Removal from State crematory or other place)		,
altin rmit. P spartme uportan jury or		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Terripera	eague, UA
ம் இத்தித் Physician	4	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir	- 100- (-327	Church St.
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Cardiomegaly	atory arrest, snock, or heart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):		
	ner	Sequentially list conditions, b. Due to (or as a consequence of): cause. Enter Underlying Cause		
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760, cate be ex physician he burial			23d. Date of delivery	,
Box 6876 te death certificate the attending phy led for use as the b	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)		Day Year
Bo, he deatly the att	hysi	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		
Division of Vital Records, P.O. E at or Attending Physician: The law requires that the rs after death. "I Director: After this certificate has been signed by the funeral director, page 2 should be detached to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the co	2	1	3e. Did tobacco use contribute to 1 Yes 2 ✓ No 3 Prob	
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9 - = >	- 1	1 29a. Centiler .	the cause(s) and manner as state	ed.
To the within To the comple	Medical	29b. Signature and title of certifier 29c. License number	29d. Date signed (Mon	
		Marjona Due Yhell O.C.M.E.	September 25, 20	
Jan Jan		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		
Stat		31. Date filed (Month, Day, Year) 0040 32. Registrar's Signature	-	
Registra	ar	SEP 27 2010 Lenux P. 7		

Apltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	
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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. VTo the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	

	•	For State State Registrar	-	Certificate of D		Reg. 1	- 7 11 11	30950				
Physicia		1. Decedent's Name (First, Middle, Last) Cynthia Lyni	n Dunsmo	nh.e.		2. Date of Death Month September	Day Year 14. 201	3. Time of Death 6:00 a ^M				
Medic Examin		4a. Facility Name (if not institution, give street and number)	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	4b. City, Town, or l	ocation of Death		c. County of Deat					
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Funeral Director			(In yrs. last birth	rday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year 12/07/19	9. Bir Co	thplace (State or Foreign untry) Illinois				
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28a-f	Director	Maryland Montgomery		Poto	mac			1 ☐ Yes 2 🕅 No				
23a or st be n	al D	10e. Street and Number 11731 Glen Mill Road		10f. Zip Code	20854	10g.	Citizen of What Co	S.A.				
items (Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of His If Yes, specify Cuban		cify Yes or No-	14. Race - Ame	rican Indian,				
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th and		19a. Informant's Name/Relationship (Type, Print) Mark Dunsmore - Brother		Mailing Address (Street ar								
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within To the complete		29b. Signature and title of certifier	A A	29c. License			Date signed (Mont)					
3		1 Keeth Kligg Co	uen s		D33159	Se	ptember	14, 2010				
		30. Name and address of person who completed cause of de Ruth Kevess-Cohen. MD. 87	eath (Item 23a) (Ty 00 Georg	ype, Print) Jia Avenue. :	#400. Sil	ever Sprin	g. Marul	and 20910				
Stat Registra	_	Ruth Kevess-Cohen, MD, 87 31. Date filed (Month, Day, Year) 37 Registra SEP 20 2010	r's Signature	pares	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 16, 2010 Year 2:00 a M Robert Francis Doherty Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Hospital Takoma Park Mon topomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F Months Days Hours Min. March 12, Year 942 013-32-4459 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c, City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12604 Laurie Drive 20904 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married XX Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72., h and Mental Hygiene.
7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Research Chemist Federal Government Be 18. Mother's Name (First, Middle, Maiden Surname)
Bessie Marie Wagner 17. Father's Name (First, Middle, Last)
Robert James Doherty ဂ permit. Page 1 and 2 should be Department of Health and Ment, Important: If item 27 is marked any injury or Act. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth M. Doherty/Wife 12604 Laurie Drive, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 k Cremation 3 Removal from State Sept. 21, Metropolitan Crematory Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Eachity Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 جدى 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ARTHOREOSCLEROTEC Physician/ disease or condition Medical resulting in death) Examiner COLONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Sician and burial-transit Cause (Disease or iinjury that initiated events that the death certificate be expecuted Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by cate has been signated bage 2 should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 N hin 24 hours after death.

the Funeral Director: After this certific
ripleted filled in by the funeral director, 25. Was case referred to medica æ 26. Place of Death (Check only one) xamino 1 Other: 2 🗌 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending work? 1 Yes 2 No Natural injury 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated The certifying Priyadian in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed, (Month, Day, Year)

State Registrar 2010 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Don Michael Coleman, MD

31. Date filed (Month, Day, Year,

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

20010 Century Blvd., Germantown, MD 20874

M 57614

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrarAMEND#5perINF,9/22/10,BMW,McCo 30952 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month 1200 AM Danie James Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death niversity Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days Hours Country)
Maryland Director **1**956 Sept. Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🖵 No Maryland Montgomery Silver Spring P 10e, Street and Number 10g. Citizen of What Country? Examiner must be with 1 23a Funeral 3720 Lamberton Square Road 20904 United States items hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", White Specify: Completed 3 Widowed 4 Divorced Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natuiury or other traumatic event, the Medical iury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Montgomery County Software/Hardware Analyst Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Robert N. Daniel Kathleen M. Clarke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other the 13223 Banks St., Bishopville, Maryland 21813 Christopher J. Daniel/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 XXCremation 3 Removal from State Sept. 20, 4 Donation 5 Dopher (Specify) Alexandria, VA Metropolitan Crematory f Huneral S Licen 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Dowe disease or condition resulting in death) hemic Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury andiogenic signed by the attending physician and defected for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.

'To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burian Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed! 2 🗆 No Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 1 Tyes မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury work 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D MO (Resident 1952536674 16 2010

Registrar

DHMH 17 Rev 7/2009

State

2. Registrar's Signature

University of Maryland Medical Center 225, Greene St. Baltimore Md 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Matthew K Folstein MD
31. Date filed (Month, Day, Year)

SFP 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2010 9 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital Easton Talbo. 5. Social Security Number **Funeral** 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 🗶 F Days Hours Min 215-14-3512 0*8/*126/119119 Director 91 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ग items 23a or 28a-। आ niner must be notified ह MD TALBOT EASTON 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26339 TUNIS MILLS ROAD 21601 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No 9 Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 3 Divorced Yes, Give 1 ☐ Yes 2 K No Specify: Specify: WHITE Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CASHIER RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOHN RUSSELL ALMIRA ELLISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LESTER A. DAFFIN / SON 31281 JOHNSON RD., SALISBURY, MD 21804 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State WOODLAWN MEMORIAL PARK 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 09/14/2010 EASTON, MD 21. Signature of Funeral Service Loenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL H
200 S. HARRISON ST., EASTON, MD 21601 HOME, P.A. part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition chemic Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 Yes 2 🗌 No 25. Was case referred to medical filled in by the funeral director. To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of within 24 hours after death.

To the Funeral Director: After to ompleted filled in by the funer. 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the 3 only one 29b. Signature and tig License number 0 0 5 3 8 / 5

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

SEP 13 2010

32. Registrar's Signature

erson who completed cause of death (Item 23a) (Type, Print)
(IC/Mosp) 9/20 Market Street Deuton MD

30954

3. Time of Death

Physician /Medica Exan

1 - For State Registrar

Funer Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, ite Medical Evantment is notified at any injury or other traumatic event, ite Medical Evantment is notified at

Baltimore, Maryland 21215-0036

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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iner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Dea	ath							
	Elkton Care/Rehabilitation Center	Elkton, MD		Cecil								
l r	5. Social Security Number 6. Sex 1	Months Dave Hours Min	8. Date of Birth (Month, Day, 03/11/	Year) 9. Bi	rthplace (State or Foreign Country) Maryland							
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ect	MD Cecil Elkton 10e, Street and Number	, MV 10f. Zip Code		10g. Citizen of What Country?								
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Funeral Director	131West Main St 11. Marital Status 12. Was Decedent Ever in U.S. 19			14. Race - Am								
표	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 	o Rican, etc.)	Black, Whi	ite, etc.							
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Be	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname) Edith Irene (Beavers) Dod									
မ	Arthur Atlas Dodson, Sr			· ·								
n e		ailing Address (Street and Number or Ru 33 Brannon Road, A			Zip Code)							
				20c. Location - City o	r Town State							
		sposition (Name of rematory or other place)	i	•								
		Mem. Gardens 109/2										
	21. Signature of Funeral Service Licensee	eral Home,	P.A. 01076									
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 28. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility 21. Name and Address of Facility 29. Name and Address of Facility 20. Name and Address of Facility 21. Name and Address of Facility 21. Name and Address of Facility 21. Name and Address of Facility 21. Name and Address of Facility 21. Name and Address of Facility 21. Name and Address of Facility 21. Name and Address of Facility 22. Name and Address of Facility 22. Name and Address of Facility 22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 28. Name and Address of Facility 28. Name and Address of Facility 28. Name and Address of Facility 28. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility 20. Name and Address of Facility 20. Name and Address of Facility 20. Name and Address of Facility 20. Name and Address of Facility 20. Name and Address of Facility 20. Name and Address of Facility 20. Name and Address of Facility 20. Name and Address of Facility 20. Name and Address of Facility 20. Name and Address of Facility 20. Name and Address of Facilit											
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dical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de constant of the desired form of the pasis of examination and/or and manner stated.											
Me	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mo.								
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	30. Name and address of person who completed cause of death (Item 23a) (Typ	pe, Print)		-	10 2 10 1 1							
	MARYANA RAD V. PULA, 126 F	A. EAST MUH SM	ect , 15	LICTUM F	וט בוז ביו							

State

Registrar

31. Date filed (Month, Day, Year)

OCT 0 1 2010

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			Registrar 1. Decedent's Name (First, Middle)	e. Last)		Cer	tificate of	Death		2. Date of De	Reg. No. 4010 30933			
	Physicia Media		Crystal Dawn I	. ,						Month Sept.	l ^{Day}	2ďľo	3. Time of Death 3:15p M	
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	<u></u>		Union Hospital 5. Social Security Number		7 A //		E1kton		0411		Ceci1			
н	Funeral Director		219-92-9606	1 □ M 2 X F	7. Age (In yrs. I	46 Yrs.	Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da Sept.		63 g. Bir	thplace (State or Foreign untry) NC	
	ld now	'n	Usual Residence of Decedent 10a, State 10b, County		10c Cit	y, Town or Loc	action							
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	the N a or 28	D.	10e. Street and Number				10f. Zip Code				10g. Citize	en of What Co		
	h with ns 23 nust }	Funeral Director	2103 Colora R	d.		· <u></u>	21917				US	USA		
·-	or iter	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	12. Was Deced	ces?		Vas Decedent of H Yes, specify Cub	lispanic Ori an, Mexicar	gin? (Spe ı, Puerto l	cify Yes or No- Rican, etc.)	14	4. Race - Ame Black, White		
9	rs afte ıral", o		3 Widowed 4 XDivorced	If Van Chin		1	☐ Yes 2 🗓 No	Specify:			Sp	Specify: White		
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations Jessica Shires			1	g Address (Street Colora				-	own, State, Zip	Code)	
ore,	of Her of Her fitem rothe		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation		20b. P	lace of Dispos	sition (Name of atory or other place			2010		ation - City or	Town, State	
<u>ŭ</u>	t. Page tment rtant: I		4 Donation 5 Other (S	Specify)		T. Foa:	rd Funer	al Hþi	me, I	P.A.		ng Sun	·	
Ba	permi Depar Impo any ir		21. Signat re de la Service I	icense MIZ	d-	22. R 1	Name and Addre T. Foar II S. Qu	ss of Facilit d Fund een Si	era <u>1</u> t. Ri	Home, sing S	P.A. un, M	D 2191	1	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between			
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POX	attend for us	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	ome of pregnal irth 2 Feta ant at time of d	∣death 3 📙	Ectopic pregnand Other (specify)	у			23	d. Date of deli Month	ivery Day Year	
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	당 첫 6 00		29b. Signature and title of certifier	gano			D CC	number	75		29d. Date s	signed (Month,	Day, Year) 2010	
	3		30. Name and address of percon	ho completed cause	of death (Item	23a) (Type, Pri	<u> 223</u>	u	, m	200	4,8	ルか	cmic	
	State Registra	~	31. Date filed (Month, Day, Year)	0 2010	istrar's Signatu	ire	backet			 				

Please Type or Print in Black Indedible Ink 508 up All Oppies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 30956 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Christine Lena Diaz Physician/ Month Dolo 1840 M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WMHS umber and Hugany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 8. Date of Birth Dec. 7, 1921 1 🗆 M 2 🔀 F 88 392-12-8290 Months Hours Director Missouri Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be notified at once. 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Allegany Luke MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States Completed by Funeral 21540 307 Pratt St. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) unknown College (1-4 or 5+) Housework Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ James Orin Nance Lovie Jane Sharp 19a. Informant's Name/Relationship (Type, Print)

Cynthia Plummer/ daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 625 W. Piedmont, St, Keyser, West Virginia 26726 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Cumberland Crematory 09/20/2010 Cumberland Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death THIRD DEGREE HOME Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence oil To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 4 ☐ Pregnant at time of death g ☐ Unknown Month Dav Year g Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by atronic Ronn 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? Yes 2 No 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, eral Director: After th filled in by the funeral 27, Manne of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and 29c. License number PITTSICIM 09/20/2010 D50844 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 912 SETON DRIVE CUMBERLAND, MD 21502 JOSE - LOVERIA JR. MI) 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 9/17/10 M.S., Kent Co. Certificate of Death Amended#18 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ September Da ZOIC 0900 AM Brendo Dickerson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Memorial Easton HOSPITAL Talbot 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours 10/30/1959 Director 50 Vrs Mary Land 213-50-4535 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Chestertown Kent ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertlat Hygiene. In Department or Health and Mertlat Hygiene. Incorparts I flem 27 is anarked other than "natural", or items 23a on any injury or other traumatic event, the Medical Examiner must be a Funeral P.O. Box 1063 21620 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Phyllis Philiss Marie Baker မ Edward Elin Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred Dickerson - Husband P.O. Box 1063 Chestertown, Maryland 21620 20a. Method of Disposition 20b. Place of Disposition (Name of 1 🗆 Burial 2XX Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation | 09/17/2010 | Chester, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fellows, Helfenbein & Newnam Kuka 130 Speer Road Chestertown, Maryland 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying and -transit Cause (Disease or iinjury that initiated events resulting in death) Last equires that the death certificate be executed Due to (or as a consequence of): nding physician ase as the burial Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 ☐ Pregnant at time of death g ☐ Unknown Day Year signed by the a g 🗌 Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 656 uc ge 2 sh 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law autopsy certificate bed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Division of Vital Certificate: To Be 26. Place of Death (Check only one) examiner? 2 X-No Other: 1 🗌 Yes 1 Hnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director; A 1 ☐ Yes 2 ☐ No Investigation Could not be filled in by the Accident Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier npleted 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL W. Morte US 2.19. (Authority) 219 South Washington St. EASTON, MS 2160/ ms 31. Date filed (Month) 32. Reg State

Registrar

State of Maryland / Department of Health and Mental Hygiene 2 [] [30958 State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September Day 16, Robert Dale Davidson 2010 2:36 a Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Carroll Westminster Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 💢 M 2 🗆 F Months Days Feb 23, Ye Hours 207-24-5283 **Director** 79 ¶931 Pennsylvania Usual Residence of Decedent Show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In the Matural", or items 23a or 28a-f shoung or other traumatic event, the Medical Examiner must be notified at. 10b. County Director 10c, City, Town or Location 10d. Inside City Limits Maryland Carroll Westminster 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2509 Mayberry Road 21158 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. white Completed 3 Divorced 4 Divorced Specify. Korea Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Computers 12 Draftsman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Alexander Wilson Davidson Mae Errett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Davidson, wife 2509 Mayberry Road, Westminster, MD 21158 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 9/18/2010 Westminster, MD Baust Church Cem. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 \-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph. sician/ Myeloid disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year been signed by the should be detached Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has be 2 s autopsy page performed certificate 2 🗌 No 1 Tes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) funeral directo Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ Dove House 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending iniurv work? 1 ☐ Yes 2 ☐ No Investigation __ Accident 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D31660 3 celes Truca k 16/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8-015 merrie WESTMINSTER MACHINE THOMAS K. GALVIN 74 799 5 TONER 31. Date filed (Month, Day, Year) SEP 1 7 32. Registrar's Signature State Darke knowa Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		Ce	rtificate of	Death		eg. No.2010	30959			
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	yland how		10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10d. Inside City Limits			
	the Maryland r 28a-f show	ctor	Maryland Carro	11			Faneytown			1 ☐ Yes 2 No			
	車 ○別	Funeral Director	3261 Hyser Road			10f. Zip Code	21787	1	0g. Citizen of What C	ountry? ISA			
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yla		10	Luther E. Bound	ls			Hilda	Sellers					
Mar			19a. Informant's Name/Relationship (Ty Gordon Davis, hus						r, City or Town, State,	Zip Code)			
		-	20a. Method of Disposition	Ī	20b. Place of Dispo		oad, Tane		20c. Location - City or	Town, State			
Baltimore,			1 ☐ Burial 2 🂢 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	nemoval nom State	Carroll	Cremator	y 9/14	/2010	Winfield,				
Bal			21. Signature of Funeral Service License	on hard	22 ا	2. Name and Addre	ess of Facility Myst Limore St	ers-Durb . Tanevt	oraw Funer own, MD 21	al Home 787			
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Division	or Atte after dea Directo in by th	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director director, the funeral director director, the funeral director director director director.	Medical C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	sician: To the best of mer: On the basis of ex and manner stated	amination and/or inv	n occurred at the til vestigation, in my c	me, date and place, opinion, death occur	and due to the c red at the time, d	ause(s) and manner a ate and place, and du	as stated. e to the cause(s)			
	To the within To the compl	Me	29b. Signature and title of certifier	3 N		29c. Licens	e number	2	9d. Date signed (Mon	th, Day, Year)			
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	10		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type, I	Print)	0						
	Sta	e	Vr. Satish Shah, &	32. Registrar's	Signature	Cettyst	1415, 19.1	7325					
	Registra	-	SEP 1 4 20	100	A A	ared.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 7:00 Alan Douglas Dexter 2010 Sept Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 14049 Howard Road Howard Dayton 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs **Funeral** Min. 1 😾 M 2 🗆 F Months Hours 80 Director 001-20-0604 1930 H. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director MD Howard Dayton 1 Yes 2 XNo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 14049 Howard Road 21036 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 No 1951 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ₩ Widowed 4 Divorced Completed 1955 Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thi any injury or other traumatic event, the Physicist schools Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edgar Dexter Ruth Sturdevant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Judith F. Coleman, stepdau. 14049 Howard Rd., Dayton, Md. 21036 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/17/10 Hampstead, Md Hampstead Cemetery Signature of Funeral Service Licenses 22. Name and Address of Facility Eline Funeral Home M00741 errm 934 S. Main St Hampstead. 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death wovonc Immediate Cause (Final Physician/ INCOR disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? Yes 2 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 1 🗌 Yes 2 🗆 Nd 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1. ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Natural 5 Pending Investigation Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 2010 WJZ ETIVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mn 20152 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep State of Maryland / Dep Registrar Ce	rtificate of Death	Mental Hy	Reg. No.	30961		
	Physicia		1. Decedent's Name (First, Middle, Last) David Arnold Dentler		2. Date of De	nath	3. Time of Death 8:02 p M		
	Medic Examin		4a. Facility Name (if not institution, give street and number) 5615 New Cut Rd.	4b. City, Town, or Location of Death Marbury			4c, County of Death		
	Funeral Director		5. Social Security Number 310−82−5685 6. Sex 1 △ M 2 □ F 7. Age (In yrs. last birthday) 49 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir	th 9. Bi	rthplace (State or Foreign puntry)		
			J, 1701	10d. Inside City Limits					
	Marylan 28a-f sh otified a	irecto	10a. State 10b. County 10c. City, Town or L MD Charles Marbury				1 ☐ Yes 2 💢 No		
	with the s 23a or 3 ust be n	Funeral Director	10e. Street and Number 5615 New Cut Rd.	10f. Zip Code 20658		10g. Citizen of What C	ountry?		
9000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene, Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ⚠ Married 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 【 No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit Specify:			
Baltimore, Maryland 21215-0036	within 72 ho jiene, er than "nai the Medica	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation kind of work done during most of work DO NOT use retired) gt. 1st Class	king	US Army	s Industry		
and	oe filed vental Hyg	To Be	17. Father's Name (First, Middle, Last) Howard Dentler		ne (First, Middle,	Maiden Surname)			
ary	should k and Me is mark aumatic		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mail	ing Address (Street and Number or Ru			ip Code)		
e, S	and 2 s Health tem 27		20a. Method of Disposition 20b. Place of Disp	5 New Cut Road Man	rbury,MD	20658 20c, Location - City o	r Town. State		
imor	Page 1 ment of tant: If it jury or c		t Rurial 2X Cremation 3 Removal from State cemetery, cre	matory or other place) ld-Echols Crem.9/1		1			
Ball	permit Depart Impor any in		21. Signature of Funeral Service Licensee M00945	² AREHART ECHOLS FU 211 St. Mary's Ay			0646		
TV	Pnysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a Carcinoid S	ter the mode of dying, such as cardiac					
	Medical Examiner		resulting in death) Due to (or as a consequence of):						
	red nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury						
o	icate be executed physician and s the burial-transit	ledical Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):						
38760	irtificate ling phy e as the		IF FEMALE: 23c. If yes, outcome of pregnancy						
. Box 68	he death certific y the attending iched for use as	Physician/N	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	Day Year		
ds, P.O.	quires that the dea en signed by the a ould be detached i	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		obacco use contribute t	o the cause of death?		
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Completed				psy prior to ormed? death?	utopsy findings available completion of cause of es 2 No		
Vital	ysician s certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (Chec		dence 6 Other (Spe	cify)		
on of	arding Phy arth. Ir: After thi ne funeral o	Certificate: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) injury			how injury occurred	S.,,,		
Divisi	al or Atte s after de l Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (City or Tox	Street and Number or Ro vn, State)	ural Route Number,		
_	n 24 hour n 24 hour e Funera	Medical	29a. Certifier (Check (Check only one) 1 ▼ Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investigation of the basis of examination and/or investigation.	stigation, in my opinion, death occurred	at the time, date	and place, and due to the	cause(s) and manner stated.		
	To th within To th comp	~	29b. Signature and title of certifier	29c. License number D28352		29d. Date signed (Monitorial Sept. 19,	th, Day, Year)		
	22112	10	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)					
J	NO QU Star	√Ar te	K. Mathur, M.D. P.O. Box 1703, La PJ 31. Date filed (Month, Day, Year) SEP 20 2010	ata,MD 20646					
	Registra	ar	31. Date filed (Month, Day, Year) SEP 20 2010 Legistrar's Signature	de					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Esther Delozier Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland WMHS-RMC 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 □ € Feb 9 1923 PA Director 193-14-6442 87 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland rinent of Health and Mental Hyglene. It ant If if the 27.5 is marked other than "natural", or items 23a or 28a-f sho inty or other traunatic event, the Medical Examinar must be notified at jury or other traunatic event, the Medical Examinar must be notified at 10a. State Director WV Mineral Ridgeley 1 Yes 2 Xlo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral RR 3 Box 1 26753 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Specify. white 3 XVidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Bessye (Price) Mulhollen Scott Walker Mulhollen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

r Rt. 3 Box 2 Ridgeley WV 26753 19a. Informant's Name/Relationship (Type, Print) Betsy Delozier Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place)
Abe Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 9/19/201 WV Short Gap 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No signed by the atte Month Pregnant at time of death 5 Other (specify) 9 Unknown 1 ☐ Yes ∠ ☐ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 XNo 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? anemia 24a. Was an autopsy page 2 perform After this certificate 1 ☐ Yes 2 ☐ No Yes 2 WNc 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 2 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28c. Injury at work?
1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗌 No 24 hours after death. Funeral Director; A Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 📡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 3 only one 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) 30. Name and add 000 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

0 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State	of Mary	land / Depa				lental Hy	giene		
	1 - State Certificate of Death Reg. No. 2										2010	30963	
	Physicia	n/	 Decedent's Name (First, Middle, La. Mary Helen Eiden 				2. Date of De Month	Day Year		3. Time of Death			
	Medic	al .	4a. Facility Name (if not institution, give	street and nur	mher)		4h City Toy	y, Town, or Location of Death				2010 ounty of Death	2:15 p M
	Examin	er	Montgomery Hospice-		Derv		noi Death		40.0	•	topmery		
	Funeral		5. Social Security Number 6. S	ex		rs. last birthday)	If Under 1 \	Year If Und	er 24 Hrs.	8. Date of Bir	th	g. Birtl	nplace (State or Foreign
	Director	l	216–58–7548	□ M 2 K F	59	Yrs.	Months D	ays Hours	Min.	July 16,	¹ 1951	Cou	D.C.
	at w	١	Usual Residence of Decedent 10a. State 10b. County		10c	. City, Town or Loc	ation						10d. Inside City Limits
	arylar a-fst fied	Director	MD	Mon topom			Spring						1 ☐ Yes 2 😾No
	he M or 28 e noti		10e. Street and Number	- 3	-5		10f. Zip Co	ode			10g. Citize	en of What Cou	untry?
	within 72 hours after death with the Maryland gjene. er than "natural", or items 23a or 28a-f show t, the Medical Examiner must be notified at	Funeral	14712 Peachwood Dr	ive			2	20905			U	SA	
	leath items items		11. Marital Status	12. Was Dec		n U.S. 13. V	Vas Decedent	of Hispanic C Cuban, Mexic	Origin? (Spe	cify Yes or No- Rican, etc.)	14	I. Race - Amer Black, White	
36	after or I", or kamir	d by	1 ☐ Never Married 2 1 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Gi	ve No			☑ No Speci			Sp	pecify:	White
3	atura cal E	Completed	15. Decedent's E	Year or D	ates.	16a, Deced	ent's Usual O	ccupation			16b. Kind	d of Business I	ndustry
212	n 72 h an "n Medi	gu	(Specify only highest gr Elementary/Seconday (0-12)	ade completed	1) 1-4 or 5+)	(Give F		lone during me	ost of worki	ng	TODI TIMO		
21.	withii giene ner th t, the		Elementary/occordary (o 12)	2		Т	eacher A	Aide			Edu	cation_	
Maryland 21215-0036	be filed vental Hygrked other	To Be	17. Father's Name (First, Middle, Last)					1		e (First, Middle,		rname)	
<u>8</u>	uld be I Men narke natic		Robert Walter Kambi			T				hryn Eis		01.1.7	0.40
<u>a</u>	of and 2 should be filed wir of Health and Mental Hygie fitem 27 is marked other r other traumatic event, the	ı	19a. Informant's Name/Relationship (Robert W. Eiden, Jr.	*						l Route Numbe Silver			
	f Heal f Heal item		20a. Method of Disposition			Ob. Place of Dispo	sition (Name o	of		Date	20c. Loca	ation - City or	Town, State
E 0	Page ant o ant: If ury or		1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec.		n State	cemetery, cren Metropolit			Sept 2010		Alexa	andria,	VA
Baltimore,	permit. Page 1 a Department of I Important: If its any injury or of		21. Signature of Funeral Service Licen	see		22 F	. Name and A	ddress of Fac	ility ns Fune	eral Home			
m	8 2 E E 2		James S	L Oca	2	50	O Univer	sity Bl	vd. W.,	Silver	Spring.	, MD 209	01
			23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										
- rue	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)			r with Met	astasis						8 yrs
	Examiner		resulting in death)	Due to	(or as a con	sequence of):							
		Jer	Sequentially list conditions, if any, leading to immediate	sequence of):						$\overline{}$			
	ansit	Examiner	Cause (Disease or iinjury that initiated events										
	exect an an rial-tr	Ĕ	resulting in death) Last										
9	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit.	dical		d				-					
289	ertifica ding p se as 1	/Me	IF FEMALE:	23c. If yes, ou	itcome of pr	egnancy					200	3d. Date of deli	ivon
Box	attendattende	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 KNo	1 🔲 Live	Birth 2 🗆 gnant at time	Fetal death 3	Ectopic pred Other (speci				23	Month	Day Year
	the de	Physician/Me	g Unknown	g 🗌 Unk	nown								
P.0	The law requires that the rate has been signed by t page 2 should be detach	by P	Part II. Other significant conditions	contributing to	death but no	ot resulting in the u	nderlying cau	se given in Pa	art I.				the cause of death?
ds,	quires en sig vuld b	ted								1 🗆	Yes 2	No 3□Pr	obably 4 Unknown
Sor	5 0001	Completed								24a. Was auto	psv	prior to c	opsy findings available completion of cause of
Xe.	sician: The la certificate ha lirector, page 2	Con	- nave							1 Yes	ormed? 2 No	death?	2 🗆 No
ā	ician: certific ector,	m	25. Was case referred to medical examiner?	Hospital: _				26. Place of D					TTo and ma
Division of Vital Records,	Phys	은	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date	e of injury	2 ER/Outpatier 28b. Time of		Injury at		me 5 🗌 Resi 28d. Describe l			Hospice
o uc	nding ath. :: After e fune	cate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation		nth, Day, Yea	ar) injury	м	work? 1 ☐ Yes 2	- 1				
<u>ISI</u> C	- Attel er deg ector by th	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Plac	e of Injury - A	At home, farm, stre	eet, factory, o	ffice		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
2	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,												<u></u>
	Hosp 24 hou Fune eted fi	Medical	(Check 2 Medical Exan	niner: On the ba	asis of exami	nowledge, death on the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of th	igation, in my	opinion, death	occurred at	t the time, date	and place, a	ind due to the o	cause(s) and manner stated.
	othe othe omple	Σ	only one) 3 Certifying Nu 29b. Signature and title of certifier	rse Practioner	: To the best	of my knowledge, o		icense numbe		e, and due to tr		signed (Month	
	10		1 Offera V	7				D	37142		Sept.	15, 201	.0
	10		30. Name and address of person who					00050					
						ve, Rockvi		20850					
	Stat Registra		31. Date filed (Month, Day, Year) SEP 1 6 201 (Dens	negistrar's S	Signature Jan	S.						

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 17, 2010 6:50A M Bernard Martin Farmer, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8205 Killean Way Potomac MOntgomery 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Month, Day, Ye Sept 26, 1 🗶 M 2 🗆 F 1921 Virginia 404-14-3641 Director 88 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Potomac Montgomery MD 10g. Citizen of What Country? 10f. Zip Code Funeral USA 8205 Killean Way 20854 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", Specify: White Completed 3 XWidowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Salesman Jewelry Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Melissa Ellen Davis John Farmer permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic a 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8205 Killean Way Potomac, MD 20854 Stephanie Goodman/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 09/20/10 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Semice Licenses Golffga Homes Cfemation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Renal Failure years Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death Yes 2 No the g 🖂 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Hypertension Completed certificate has been sirrector, page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? • Hospital or Attending Physician: The law 24 hours after death.
• Funeral Director: After this certificate has t autopsy performed? Yes 2 X No 1 🗌 Yes 2 🗌 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🗆 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

4

State Registrar 31. Date filed (Month, Day, SEP)

DHMH 17 Rev 7/2009

MD

egistrar's Signature

course

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D33677

Edward J. Devin, M.D. 20500 Seneca Meadows Pkwy. Suite 2400 Germantown, MD 20876

September 17, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEMTEMBER Day 13 2010 11:00A M JEROME M FORD SR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, Ye April 19 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Min. 1 🛛 M 2 🗆 F Months Hours Maryland **~**1929 **Director** 81 219-22-9885 Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò er than "natural", or items 23a on the Medical Examiner must be Funeral 2505 Hemingway Drive 21702 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 Married X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Specify: 3 ☒ Widowed 4 ☐ Divorced Completed Year or Dates. WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Railroad 11 Yardman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alice J. McCauley Raymond W. Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3943 Rexford Drive Hemet, California 92545 Anna V. Burd / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State September 4 Donation 5 Other (Specify) Stauffer Crematory 16, 2010 Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Pike Frederick, Maryland 21702 outh 1621 Opossumtown Pike 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ rove disease or condition resulting in death) Medical Tue to (or as a consequence of): Examiner Sequentially list conditions. Examine cause. Enter Underlying Due to force a nonequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been also as a second of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the Cause (Disease or linjury the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4 Pregnant g Unknown Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown detached s been signed by the should be detach Part II. **Other significant conditions** contributing, to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 autopsy perform death? 1 Yes 21 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital the funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be within 24 hours after dea To the Funeral Director completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

Registrar

State

ZHIVA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Date filed (Month, Day, Year)

SEP

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	_	-						All Copi		_	ible.		
	-	1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2									30066					
		Registrar 1. Decedent's Name	e (First, Middle	e, Last)			CE	illilla	ie oi L	Jealii	2. Date of		No.	U	3. Time of Death	_
Physiciar Medic		LARRY						SEPTE	MBER	Day 13 2	2010	2:00 P M				
Examine	_	4a. Facility Name (if not institution, give street and number)						4b. Cit	y, Town, or	Location of De	ath		4c. County	of Death		
<i>}</i>	FREDERICK MEMORIAL HOSPITAL 5. Social Security Number 6. Sex 7. Age (in yrs. last birth						act hirthday		FREDE ler 1 Year	RICK If Under 24 H	re la Data at	Dinah	FRED			_
Funeral Director	265-62-1448 1 X M 2 □ F 68 Yrs.							Month		Hours Mi		Day, Yea 14,	1942	Ten	place (State or Foreign ntry) nessee	
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// Aaryla 8a-f s tified	rect	Maryland	Fred	erick	ick Brun			ınswi	.ck						1 X Yes 2 No	Э
a or 2 be no	Funeral Director	10e. Street and Nun		10f. Zip Code						_	ntry?					
th with ms 23 must	ner	32 East	Orndor			- III	n I40		217		10 11 M		Jnited			
, or	2	11. Marital Status1 Never Marri3 Widowed		ried	Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	?	If Yes, specify Cuban, Mexican, Puerto					ecify Yes or No- Rican, etc.) 14. Race - Am Black, Whi Specify: Wh			etc.	
2 hou "natu	plet	(Spe	15. Decede						ual Occup	ation Juring most of w	orking	16b	. Kind of Bu	siness Ir	dustry	
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id 2 should salth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Nancy Frazier / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 32 E. Orndorff Dr., Brunswick, MD 217								tate, <i>Zip</i> 716	Code)					
Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disp 1	Cremation		noval from Sta	Re	Place of Disponentery, cress thave	osition (Nematory or en Cr	ame of other place emato		t. ^{Date} 15, 2010		ederi		own, State Maryland	
permit. Departr Imports any inji		21. Signature of Tuneral Service Licensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701														
		23a. Part 1. Enter the dispuse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between														
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Medical Examiner		resulting in death)				o (or as a consequence of): 5 tro/ce									week <	
sit	Examiner	Sequentially list co if any, leading to im cause. Enter Under Cause (Disease or			a consequence of):											
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To th withi To th		29b. Signature and	title of certifie	r				2	9c. License			29d. Date signed (Month, Day, Year)				
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(0		30. Name and addre	ess of person Tawa		leted cause of	death (Item	1 23a) (Type,	1	M	0	2170	2				
State Registra		31. Date filed (Monti		162	32. Regis	par's Signa		Saa	Kel	-						_

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Robert Stannard	Fla	nagin State of Maryland /		t of Healt	h and Mei		Reg. N	2010	3096
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		4a. Facility Name (if not institution, give street and number)		4b. City, To	own, or Location			4c. County of Deatl	1
-		21520 Morris Drive		Lexing	ton Park			St. Mary's	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		r 1 Year If Und		f Birth(M	IM/DD/YYYY) 9. Bir	
Director		212-66-5189 1XM 2 F	54	Yrs. Months	Days Hour	s Min. 11/1	/195	55 Foreig	ountry) Kansas
		Usual Residence of Decedent							
* any			Dc. City, Town or L	ocation					10d. Inside City Limits
and Show	Ь	Maryland Saint Mary's		Lexi	ington E	ark			1 Yes 2 X No
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212 Ment b Ment mark	0	19a. Informant's Name/Relationship (Type, Print)	City or Town, State	, Zip Code)					
MD nd 2 sho alth and m 27 is aumati	Ė	Elizabeth Diane Flanagin / Wife	215	20 Morris	s Drive.	Lexington Pa	rk. M	Ф 20653	
e, P		20a. Method of Disposition	20b. Place of Di	sposition (Name or other place)	e of cemetery,	Date	20	c. Location - City or	Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation 3 Removal from State	St. George	e's Catho	lic	October 1, 2010		Valley Lee	, Maryland
nit. P artme sortar		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Chur	<u>*Ch</u> 22. Name and A	Address of Facili	y Mattinglev	-Gard	liner Funera	al Home, P.A.
Dep Dem Dep Inju		Kenneth Phila.						Leonardtown	
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Division

To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: A completely filled in by the fur Certificati Medical

> State 31. Date filed (Month, Day, Year) SEP 29 2010 Registrar

2

Accident

29b. Signature and title of certifie

3 Suicide

Investigation

vathall, me 30. Name and address of person who completed cause of death (Item 23a)

6 X Could not be determined

Pamela E. Southall, MD Assistant Medical Examiner

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

28e. Place of Injury - At home, farm, street, factory, office building, etc.

house 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s).

111 Penn Street, Baltimore, MD 21201

unknown

28f. Location (Street and Number or Rural Route Number, City or Town, State) 21520 Morris Dr. Lexington Park, Md.

September 28, 2010

OCME

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:15a M DONALD PARSONS September 23,2010 FREELAND /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dennett Road Manor Nursing Home Oakland Garrett If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs, last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F 232-42-6258 Director 6/23/1920 WV Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Evanturer out for notified at Director MD Garrett Oakland 1 XYes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10 Liberty Sq Drive 21550 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1. ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Residential 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harland Freeland ျှ Lucy Parsons Freeland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Freeland/spouse 10 Liberty Sq. Dr Apt 11, Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages 1 Department of H Important: If ite any Injury or of once. ₩ Burial 2 ☐ Cremation 3 ☐ Removal from State Terra Alta Cemetery 4 Donation 5 Other (Specify) 9/26/2010 Terra Alta, WV 22. Name and Address of Facility
Arthur H. Wright Funeral Home
105 Highland Avenue, Terra Alta, WV 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 26764 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner erro Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760. signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s perform of Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fur death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Inomas

31. Date filed (Month, Day, Year)

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m.D.,

Registrar's Signature

Johnson

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			Cremation	3 □Removal from	State		netery, crer arts (-			Septe 28, 2	ember 2010				st, MD	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur		29a. Certifier (Check only		ng Physician: To the	oasis o	f examination											
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09 ROBERT PAUL GANNON, SR. **C**Y 2010 12:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TALBOT WILLIAM HILL MANOR EASTON 5. Social Security Number . Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Hours Min 0672271928 214-28-3233 82 Director MD Lisual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD TALBOT **EASTON** 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or any njurry or other traumatic event, the Medical Examiner must be a once. Funeral 8514 MILES COURT 21601 UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 FARMER AGRICULTURE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ JAMES LEO GANNON ETHEL M. RHODES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8514 MILES CT., EASTON, MD 21601 ROBERT PAUL GANNON, JR. / SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State SPRINGHILL CEMETERY 09/09/2010 EASTON, MD 4 Donation 5 Other (Specify) Signatur Funeral Service License 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA
200 S. HARRISON ST., EASTON, MD 21601 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only the cause on each line. Approximate Interval Between Immediate Cause (Final LA Reath Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Dav Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Unknown signed by t 23e. Did tobacco use contribute to the cause of death? ASCUD, PRIOR CV 1 Yes 2 No 3 Probably 4 Unknown 1 MOMA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy certificate has Yes 2 N 1 Yes Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury s after death. Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination allows investigation, in my opinion, obtained and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

within 24 hours Signature o completed cause of death (Item 23a) (Type, Print) 00MIN60 State Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Regis#MEND#20a,b,c,perINF,9/28/10,BMV,MccoCertificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year TEDDY JAMES GREENE Sept 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yearch 24 1 X M 2 T F Months Hours Min. 215-55-0372 Director 74 1936 Sierra Leone March Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11558 Lockwood Drive, Apt #B-1 20904 Sierra Leone 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmin. Elementary/Seconday (0-12) College (1-4 or 5+) Security Guard Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Alexander M. Greene Regina T. Leigh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita D. Scott/Daughter 8335 Snowden Oaks Place, Laurel, Maryland 20708 20b. Place of Disposition (Name of George of Washington) Cemetery 10 20a. Method of Disposition 20c. Location - City or Town, State

Adelphi, Maryland
Brentwood, Maryland 1 X Burial 2 X Crer tion 3 🗆 Removal from State ncoln Crematory | 10/ 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. No #1070 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the dis ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate shock, or heart failur Immediate Gause (Final Onset and Death Physician Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Ventricular Fibrillation / Torsades Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year ed by the a signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed death? certificate 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🔀 No Other: ျှ 1 A Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this : After this funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work n 24 hours after death.

The Funeral Director: Af bleted filled in by the fu 1 Tes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

MID

Smitha Bhikkaji, MD, 1500 Forest Glen Road, Silver Spring, MD 20910

Wh

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0064100

September 17, 2010

Registrar
DHMH 17 Rev 1/2001

State

600 N.Wolfe Street Baltimore, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Narla

Registrar's Signature

Venkata

SEP 20 2010

31. Date filed (Month; Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ T9 James E. Gooden 2010 8:45 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10117 Frederick Road Ellicott City Howard Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 215-32-2049 19971935 75 Director V/A Usual Residence of Decedent f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🛂 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10117 Frederick Road 21042 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian 1 Yes 2 No
If Yes, Give
Year or Dates. Armed Forces 2 1 Never Married 2 Married Black White etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Hygiene. other than "natural", 3 🗌 Widowed 4 🗆 Divorced Completed White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Auto is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ James I. Gooden Lula Shifflett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health E. Jane Gooden - Wife 10117 Frederick Rd. Ellicott City. MD 21042 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 Important: If it any injury or o cemetery, crematory or other place)
Good Shepherd Cem. 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 9/20/2010 4 Donation 5 Other (Specify) Ellicott City, MD 22. Name and Address of Facilit Harry H. Witzke's Family F.H. Inc 21. Signature of Funera Service Licensee M01411 C2 1 4112 Old Columbia Pike Ellicott City 23a. Pa 1. Enter the I sease, or complications that caused the death. Do not enter the mode dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final esture Physician/ disease or condition Medical resulting in death) Due to (or a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events that the death certificate be executed tran-Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown g Unknown P.O. signed t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 1 ☐ Yes 2 ☐ No 21 Yes within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes Other: 2 No မ 4 Nursing Home 1 Inpatient 2 I ER/Outpatient 3 I DOA 5 Residence 6 Other (Specify 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? Natural 5 Pending Investigation Could not be 2 🗌 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check ☐ Medical Examiner: On the basis of examination and/or investigation, in my opiniori, ueatil occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and tit/9 29d. Date signed (Month, Day, Year) 2010 116206

State Registrar Registrar's Signature

30. Name and address of personatio completed cause of death (Item 23a) (Type, Print)

FIITORFTH VALLAN, L.D. 1380 W

ELIZABETH
31. Date filed (Month, Pay,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 16, Physician/ 2010 Nina Gorban 5:30 PM Medical 4a. Facility Name (if not Institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wilson Health Care Center Gaithersburg Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Russia 1 🗆 M 2 🗶 F 87 Hours Min. (Month, Day, Year 216-23-1770 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3624 Peartree Court, Apt.# 14 20906 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 😿 No Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: 3 X Widowed 4 ☐ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th Bookkeeper Bookkeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alexander Zuev Alexandra IInknown 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is n 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tatyana Kaplun (Daughter) 13803 Grey Colt Drive, Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September cemetery, crematory, or other place)
Norbeck
Memorial Park 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 17, 2010 Olney, Maryland 21. Signature of F uneral Service Lice DeVol Funeral Home, 22. Name and Address of Facility 10 E. Deer Park Drive, Gaithersburg, MD 20877 M00689 Hart 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Kure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of Exami attending physician and for use as the burial-transit Due to (or as a consequence of): that the death certificate be exer resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Day 5 Other (specify) Year Pregnant at time of death the g 🗌 Unknown 9 Unknown is been signed by the should be detach. P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed?

Yes 2 No this certificate 2 No 1 Yes 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Be 2 No Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 00062435

Registrar
DHMH 17 Rev 7/2009

State

10110

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

cleCular Dr. Roctville, MD 80878

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day numas 302 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day Sept 19 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F 1<u>931</u> **Director** Maryland 218-26-4268 78 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 ☐ Yes 2 X No 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 29 West Washington St. Apt 403 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Korean 1 ☐ Yes 2X No Specify: Completed 3X Widowed 4 □ Divorced Specify: Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 salth and Mental Hygiene. 127 is marked other than "rer traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) 8th 0 Farmer Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas R. Holland Sr Mary I. Sellman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau James H. Holland (Brother) 203 Castle Way Lane Houston, TX 77015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 9-17-10 Chews UM Church West River, Md. Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee MMarme RAABISE of PacilitSons Mortuary, P.A. 821 West St. Annapolis, Md. 1100483 23a. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examin attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes No Month Day Year signed by the a d be detached f 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medica Division of Vital Hospital or Attending Physician: funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending nours after death.

neral Director: Aff Accident 1 Tyes 2 No Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 🗆 To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) \$13 9/13/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd Suite 8, Severna Parte, MD 21146 MO. MESSICY 821

Registrar

State

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HOES Year 14RONE LEF 2010 5.15A M **を**りり Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sanctuary @ Holy Cross Burtonsville Montgomery 5. Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Feb 21 ^{Year} 1939 Maryland Director 213-36-8100 71 Usual Residence of Decedent or 28a-f show the notified at 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland Howard Ellicott City 1 ☐ Yes 2 🛣 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? pe 1 and 2 should be filed within 72 hours after death with the of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be by Funeral 9214 Frederick Rd. 21042 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 1 9 6 1 - 6 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. Elementary/Seconday (0-12) College (1-4 or 5+) 12th 6yrs Educator Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Hoes Hattie Lee Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Faye Hoes(Wife) 9214 Frederick Rd. Ellicott City, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran 9 - 21 - 10Crownsville, Md. permit. Manne Roams Coff Macility Sons Mortuary, P.A. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Rese MO0 783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death ANCEK Physician/ UNG disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Unknown Part II. **Qther significant conditions** contributing to d ath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PIRATION MEUMONIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown TYPERTENSION Were autopsy findings available prior to completion of cause of 24a. Was an autopsy PARKINSON 1 Tyes Yes 2. W/No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other ျပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Funeral Director: After this completed filled in by the funeral directions 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatu and title of certifier 29c. License number 28575 aun Melle

To the within To the complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete

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State Registrar 2835

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tame and address of person who completed cause of death (Item 23a) (Type, Print)

1 6 2010

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1 ASNE BM

31. Date filed (Month, Day, SEP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Tabitha B. Howden State of Maryland / Department of Health and Mental Hygiene 30977 2010 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3 Time of Death **Medical Examiner** TABITHA BROOKE HOWDEN 1032 hrs September 9, 2010 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Easton Memorial Hospital Talbot 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) Director Months Days Hours 217-13-5188 1 M 2 X F 24 02/28/1986 Country) MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD TALBOT 1 Yes 2 X No **CORDOVA** death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 12634 PEACH LANE 21625 UNITED STATES Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces Never Married 2 X Married White, etc. 2 X No 1 Yes 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: WHITE Specify: ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "1 injury or other traumatic event, the Medical E College (1-4 or 5+) CERTIFIED NURSING ASSISTANT HEALTH CARE 2 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) GARY R. BARTON Be BRIDGET WATKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT J. HOWDEN/HUSBAND 12634 PEACH LANE, CORDOVA, MD 21625 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State NEAVITT CEMETERY 09/15/2010 NEAVITT, MD 4 Donation 5 Other Specify 21. Signature of Funeral Service Lice FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one gause on each line. Between Onset and /Medica a Head and Neck Injuries Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examine Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last his certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - transi d sician/Medical UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 V Unknown 9 Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 🗸 Yes ✓ Yes 2 No 2 No 25. Was case referred to medical or Attending Physician: 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes မ 2 No 28a. Date of Injury (Month, Day, Year) Sep 9, 2010 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Driver auto auto collision Natural Director: 1 in by the f 5 Pending 1 Yes 2 ✓ No hours after death. 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) 12721 Ocean Gateway, Cordova, MD determined To the Hospital (Specify) Major Road / Highway To the Funeral __ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 10, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Marth 32 Registrar's Signatur State

Registrar

OCME

State

Registrar

31. Date filed (Month, Day, Year)

SEP

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 14, Physician/ 201.0 September 5:40 SHIRLEY IRENE HANN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Mt. Airy Kline Hospice House If Under 1 Year If Under 24 Hrs. Social Security Number Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 D F Months Days Hours Min. Nov. 5, Year) 31 Mary Tand Director 78 214-28-5969 Usual Residence of Decedent show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick Frederick 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6926 Fish Hatchery Road 21702 U.S.A. death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. ģ 1 Never Married 2 Married 72 hours after Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Midowed 4 □ Divorced If Yes, Give "natural", Specify: Completed Year or Dates White other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Piece Worker Canning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Nunamaker Herbert Sweeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trai 5002 General Stuart Court, Sharpsburg, MD 21782 Marvin L. Hann Jr. / 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Resthaven Mem. Gardens 9/17/2010 Frederick, Maryland 21. Signatur f Fy eral Service Licensee ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. EAST MAIN STREET, THURMONT, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Due to for as a consequence on Exami Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 Pregnant at time of death the Unknown 9 Unknow þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsv 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence nin 24 hours after death.

the Funeral Director. After this impleted filled in by the funeral dil 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending Accident 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the F 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 30980 State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HELEN THERESA HAZZARD **Physician** SEPTEMBER-27-10 3:40A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES CHAS.CO.NURSING & REHAB.CNTR. LA PLATA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | JULY 3, 1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign NEW JERSEY 1 M 2 X 157-01-2151 94 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD CHARLES LA PLATA tx es 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 10200 LA PLATA ROAD 20646 U. S. A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedo... Armed Forces? 1 ∏Yes 2XINo 1 ∐Yes 2**½** If Yes, Give Year or Dates: 1 Never Married 2 Married þ 1 □Yes 3 □No Specify: Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 JEWELRY BUYER DEPARTMENT STORE 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) WALTER BENTLEY LEEK BESSIE YOUNG 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11330 DOBBINS LANE LA PLATA, MD 20646 RICHARD A. HAZZARD/SON 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State OCTOBER 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State CEDAR HILL CEMETERY 1,2010 4 ☐ Donation 5 ☐ Other (Specify) SUITLAND, MARYLAND 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 21. Signature of Funeral Service Licensee M00641 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Mmoura disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner Directo (or se a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 14 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760 attending physician for use as the buria the þ has certificate director, this funeral n 24 hours after des ne Funeral Directo within 24 hc

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Funeral

Director

general restural, or items 23a or 28a-f show the Medical Evaration in ust be notified at

of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me

Pages 1 and 2 should be nent of Health and Mental

permit. Pages Department of Important: If it any Injury or o

Physician

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Registrar's Signat

29c. License number

FCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

ldwashirsten Rd, worldwy, md 20002. N. Jayanthan, md

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please	e Type or Print in State of Maryla				-	_	e.			
	•	For State Registrar			rtificate of l			Reg. No.201	0 30981			
Physicia Medic			enetta Parham	Hill			2. Date of Dea Month Septem		3. Time of Death 7:03 pm			
Examin	er	4a. Facility Name (if not institution, giv				r Location of Death		4c. County of Death Montgomery				
Funeral		5. Social Security Number 6. S										
Director		578-32-5967 Usual Residence of Decedent	T L M 2 LQ F	86Yrs.	World S Days	Tiouis Iviiii.	0.8/21/	1924 No	rth Carolina			
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ne Mar or 28a- notifii	Dire	Maryland Montgo	omery		10f. Zip Code	silver Sp.	ring	10g. Citizen of What	1 Yes 2 No			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyclene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	6 Shannon	Court			20904			I.S.A.			
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ysiciar s certif directo	To Be	examiner? 1 Yes 2 No	Hospital:	☐ ER/Outpatier	Oth	er:		ence 6 Other (Sp	pecify)			
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To the within To the comple	Σ	29b. Signature and title of certifier	se Practioner. To the pest of	Tily knowledge, c	29c. License			29d. Date signed (Mo				
7		Kshawa	crang			D60826		Septembe	r 15, 2010			
		30. Name and address of person who Kshama Garg. MD				ver Sprin	a. Marul	2and 20910				
Stat	_	31. Date filed (Month, Day, Year)	32 Registrar's Sign			2 - 07.0010	Jy mee cyn	207.0				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state Registrar Amend#7perfuneralhome9/22/16 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gladys Emma Horton entember Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Plata Medical Cente a If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Age (In yrs. la **86 96** 8. Date of Birth **Funeral** Country)
Maryland Hours Min Director 220-16-9114 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits "natural", or items 23a or 28a-f sl edical Examiner must be notified XX Yes 2 No MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 327 Garner Road 20601 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No Black, White, etc. þ 1 Never Married 2 Married Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 Divorced Department of Health and Mental Hygiene. Important. If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Dept. of the Navy **Explosive Worker** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Cleveland Pickeral Lila Pickeral 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie DeBoe/Caretaker PO Box 285 Morganza, MD 20660 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem. Gardens Sept. 18,2010 Waldorf, MD 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licensee MBURO 3035 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner NevHon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine signed by the attending physician and a bedetached for use as the burial-transit Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pre 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 Unknown ut not refulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has page 2 autopsy performed death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: မ 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 1 Yes 2 No Accident Investigation within 24 hours after deat.

To the Funeral Director. 3 Suicide
4 Homicide 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by etermined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basin of examination and prinvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner; of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only 29b. Signa 29c. License number 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2060 State

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Paul Rena Harvey 15,2010 September Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Clinton Southern Maryland Hospital Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1**X** M 2 □ F Months Days Hours (Month, Day, Year) Country) DC Director 220 62 8162 56 01-16-1954 Usual Residence of Decedent 3a or 28a-f show be notified at 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's 1 X Yes 2 No Suitland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a #301 20746 3308 Curtis Drive the Medical Examiner must USA hours after death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify:Black 'natural", 3 Widowed W Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private 12th Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed h and Mental H **7 is marked ot** Paul Harvey Mildred Savov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau Connie Savoy/ Sister 14204 Hampshire Hall Ct.Upper Marlboro,MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cem. 09-25-2010 Clinton, MD 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensed 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death CELL LUNG CANCER SQUAMOUS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to lor as a consumience of The law requires that the death certificate be executed Cause (Disease or iinjury and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Day Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEHYDRATION 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should ANEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 ☐ Yes 2 ☐ No 2 No Yes or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 28. Place of Death (Check only one) examiner? Hospital: 2 1 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 9/15/2010 D0064986 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BB 3

DHMH 17 Rev 7/2009

Registrar

20 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Theodore Cooper September 8, 2010 5:35 P. M Hunt Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fox Chase Rehabilitation Center Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 New York 8. Date of Birth **Funeral** (Month, Day, Days 1 X M 2 □ F Months Min. 119-24-7350 79 **Director** Aua Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Me Ical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD Montgomery Silver Spring 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2015 East West Highway Funeral 20910 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 1958–1962 Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Black Completed 3 Widowed 4 K Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Surgeon Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked o Lawrence Fitzgerald Hunt Sybil Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle A. Meney/ Daughter 14052 Big Branch Dr., Dayton, MD 21036 altimore, 20b. Place of Disposition (Name of Geometry caprator Unit versity 2010 20a. Method of Disposition 20c. Location - City or Town, State Page 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Washington, D.C. 4

■Donation 5

Other (Specify) Medical <u>Center</u> 22. Name and Address of Facility Columbia Mortuary Services, P.A. Signature of Funeral Service Licensee /M00969 Steed 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Cardio Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Cardiomyopathy Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of), that the death certificate be executed the attending physician and hed for use as the burial-transi Cause (Disease or liniury Chronic Hypertensive Heart Disease that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 4 Pregnant 9 Unknown 1 Yes 2 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' this certificate 2 🔲 No 1 Tyes Yes 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific, completed filled in by the funeral director, funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

State Registrar

16

31. Date filed (Month, Day, Year)

backs

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patricia Gomez, M.D.

Box 68760

P.O.

Records,

Division of Vital

29c. License number

D63232

29d. Date signed (Month, Day, Year)

15245 Shady Grove Road Suite 130

Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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0	/Medi Examir		Thomas Willia 4a. Facility Name (If not institution, give		r)		4b. City,	Town, or	Location of	Death	sep+	4c. C	ounty of D		5 ! \
ác.	LAGIIII	2.3	15946 Falling Wat	ers Road			Williamsport			t			Wash	ington	
ō	Funeral		5. Social Security Number 6. Se		ige (In yrs. I	last birthday)	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day)	Year)	9. 1	Birthplace (State Country)	or Foreign
	Director		214-34-1089 Usual Residence of Decedent	MW ZUP	73	Yrs.					Dec. 16	,193		Maryland	
	/land		10a. State 10b. County		10c. City	y, Town or Lo	ocation							10d. Inside C	City Limits
	a-fet	tor	Maryland Washin	gton	ton Williamsport									1 🗆 Yes	2 ⊠ No
	or 28	Director	10e. Street and Number		10f. Zip Code						1	0g. Citize	Country?		
	ath w	rai	15946 Falling Wat						L795					JSA	
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lar	should be find Mental I	To B	Shull Metzger H	ebb					Sara	ah C	Charity	Kel	.ly		
Maryland	2 should be fited withir and Mental Hygiene. Is marked other than aumatic event, the Ma		19a. Informant's Name/Relationship (7	Гуре, Print)		19b. Mailir	ng Address	(Street a	and Number	r or Rura	l Route Number	, City or	Town, State	e, Zip Code)	
	of Health itam 27	1 8	Nancy L. Hebb - W	ife	20h B									MD 2179 or Town, State	5
Jor.	or of h		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐			lace of Dispo emetery, crei									.3 3
Baltimore,	permit. Page Department of Important: If any Injury or		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Liven		Gre						22,2010 e, P.A.	MITI	.1amsp	port,Mar	yıand
Ba	permit. Departr Importa any inje	1		II.								11113	mspoi	rt, MD 2	1795
8760,	Physician /Medical Examiner physician and physician and the prital-transit	cat Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	s a consequ	uence of):	·	20	J. Cl		Can)(Q/m\	q · 6 vns	2004 Ans
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1☐Live birth	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown								23d. Date of delivery Month Day Year		
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Vital	ıysician: Th ııs certificate director, pag	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only or				
of \	di S	ဥ	1 ☐ Yes 2 Ø No	Hospital: 1 Inpat		ER/Outpatier			4 LI NUI	sing Hon			Other (S	Specify)	
	Jing After fune	atlon:	27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D	jury Jay Year)	28b. Time of Injury	f 2	8c. Injun Work	yat k? Yes 2∐N	1	28d. Describe h	ow injury	occurred		
Division	i Diffe	Certification;	2 Suide 6 Could not be						28f. Location (Street and Number or Rural Route Number, City or Town, State)				mber,		
	To the Hospital within 24 hours a Vo the Funeral I completely filled	edical (29a. Certifier (Check only one) Certifying Ph	ysician: To the bestimer: On the basis and manners	of examinat	wledge, death tion and/or in	h occurred vestigation	at the tin	ne, date and pinion, deat	i piace, a h occurre	and due to the c ed at the time, d	ause(s) a late and p	nd manne place, and	r as stated. due to the cause((s)
	To th within (To th comp	Me	29b. Signature and title of certifier			1 N	290	. License	e number		2	9d. Date	signed (M	onth, Dey, Year)	
	OF		Hhiel H	CILA		ala.		01	16L	17:	3	Sep	t.21	0,20	10.
	KTI		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)		00.4		_ 11	1	1	217	40
			31. Date filed (Month, Day, Year)	ndan	trar's Signa	101	1130	0	147		-1:HC	Ade	Motor	wn, M	0
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Lindner Charles Hoefer, Jr. Sept. 2010 16 4:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4h City Town, or Location of Death 4c. County of Death 11011 Dumbarton Drive Dunkirk Calvert 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 247-48-8841 Director 78 /11/1932 Usual Residence of Decedent fshov 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Calvert 1 X Yes 2 ☐ No Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11011 Dumbarton Drive 20754 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 🗌 Never Married 2 💢 Married within 72 hours after Maryland 21215-0036 should be med and Mental Hygiene. 1 ☐ Yes 2 X No Specify: Year or Dates. 50-54 White 3 Divorced Specify: Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer D.C. Metro Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lindner Charles Hoefer, Sr. Willimetta Lincoln 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Hilke Hoefer/Wife 11011 Dumbarton Dr., Dunkirk, MD 20754 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Mem'l Gdn's 9/18/10 Dunkirk, MD 21. Signature of Functal Service Lice 22. Name and Address of Facility Raymond-Wood F.H., P.A. PO Box 430, Dunkirk, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition 18015 Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month the a signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy perform death? certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No ျ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) Twin Beaches Community Health Center

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

P.O. Box 1309, 892 Chesapeake Ave

North Beach, MD 20714 (410) 257-7279

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month September 15 2010 A M Marie Estelle Hardestv 9:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Crofton Convalescent Center Anne Arundel Crofton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 ី F Months Days Hours Min 11-29-1921 Mary land **Director** 218-28-8666 88 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6107 Drum Point Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Specify: Year or Dates white injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) salesclerk retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Owen Violetta Alvin Phipps Grace Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2075 Richard L. Hardesty, Sr., .0. Box 26, Deale, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) So. Memorial Gardens: 09-20-2010 Dunkirk, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final Onglet and Death Physician/ MOI (90) disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner uctive Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events Due to (or as a consequent of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year Yes been signed by the sale 9 Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed 1 Yes 2 No 2- No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Investigation after death Director: filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 124 hours a Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

JRW

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within 2 To the I

State Registrar

only one 29b. Signature and title of certific

Rakesh Arora,

MD. 31. Date filed (Month, Day, Year) 32. Registrar Signature SEP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

14300 Gallant Fox Lane # 222, Bowie, MD 20715

29d. Date signed (Month, Dayl Year) S

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 31988 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 September Eugene Albert 11:00 AM Hayden Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3115 Woodlow Drive Calvert Huntingtown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 😿 M 2 □ F Days Hours 1172671918 Maryland Director 91 215-16-9589 Usual Residence of Decedent 28a-f shov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Anne Arundel Pasadena 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 104 Railroad Avenue 21122 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 V Yes 2 No
If Yes, Give
Year or Dates. 1944-46 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify 3 X Widowed 4 Divorced Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 joiner shipyard should be filed with and Mental Hygier 7 is marked other t permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Bernard Wingate Hayden Juanita Shillinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3115 Woodlow Drive, Huntingtown, MD Eugene A. Hayden, Jr., son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Metropolitan Crematory 09/15/2010|Alexandria, VA Signature of Funeral Service Licen 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart follure. List only one chause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ chronic obstructive lung disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Entre I de Tying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Day Pregnant at time of death been signed by the same should be detached 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has e 2 s autopsy performed? Yes 2X No r this certificate has eral director, page 2 death? 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 X No 10 4 Nursing Home 5 Residence 6 Other (Specify)Son's home 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No neral Director; A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours

To the Funeral I

completed filled Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the caus (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Number Practice for the coal of my knewledge, shall another at the time, date and place, and due to the cause(s) and manner stated. or ly one 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) D 17324 September 13, 2010

den 5+1

DHMH 17 Rev 7/2009

Registrar

Raymon A.

31. Date filed (Month, Day, Year,

Woble,

238 Merrimac Court, Prince Frederick, MD

who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signature

M.D.,

1 6 2010 N

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 'סבסבקלס/פס 12:15 a Mary Lou Hardy Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Funeral 1 - M 2 XF Hours 12/04/1921 Director 578-36-2977 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No Washington D.C. 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral **NZA** 50007 801 Rhode Island Ave. NW 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Bace - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Private Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hardy Wiley Elbirtha Walton and lis m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 3434 Eads St. NE, Washington DC, 20019 Alberta Young / cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Resurrection Cemetery 09/14/2010 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Strickland Funeral Services 21. Signature of Funeral S-6500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner eros Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 1 ☐ Yes ∠ ≥ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an After this certificate has prior to completion of cause of death?

1 Yes 2 No autopsy performed 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier The control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the co (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D0060100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Sasi

15000

niversity

31. Date filed (Month, Day, Year) **SEP 2 0** 2010

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, 30990 Certificate of Death 1. Decedent's Name (First, Middle, Last) og Month 2. Date of Death **Physician** ROBERT R. 08 2010 **JENKINS** 1:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 700 PORT STREET, APT. 122 TALBOT EASTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Days 1**X** M 2□ F Director 577-44-3146 08/08/1933 OH Usual Residence of Decedent 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f shor event, it s Medical Experiment must be nedified at Director 1 ▼Yes 2 No MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 PORT ST., APT. 122 Funeral UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 Dayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, Ital once. LAWYER T.AW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT LESLIE JENKINS MILLIE LEONA ROWE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEAN D. JENKINS/WIFE 700 PORT ST., APT. 122, EASTON, MD 20b. Place of Disposition (Name of MD EASTERN SHORE VETERANS CEMETERY 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Mg Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/13/2010 HURLOCK, MD 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 23a Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myrcardia **Physician** disease or condition resulting in death) /Medical Due to for as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy 1 ☐Yes 2 00 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation 1 ☐Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D TG Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0751/32 MD 9-8-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12+VA ABREGO, MD 598 CYNWOOD DR., STE. 104, EASTON, MD 32 Registrar's Signature State park Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 25 per me,g908,10/01/2010dhb Certificate of Death Reg. No. Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept. ŽÖ'10 Henrietta Rita Jones 10:07 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign July 10, Year 920 1 □ M 2 🖳 F Months Hours 212-30-2433 **Director** Yrs. 90 PA Usual Residence of Decedent 28a-f shov 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Pikesville 1 Yes 2 XXVo 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral and Mental Hygiene. 8203 Arrowhead Road 21208 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. þ 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 XX ivorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 laundry worker hospital Be and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ George Thomas Shorb Henrietta Mae Hovis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, Dennise Spiegel niece 8203 Arrowhead Road Pikesville MD 21208 Baltimore, 20a. Method of Disposition

1 Berial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) St. Andrew Cemetery 09/20/2010 Waynesboro, PA 22. Name and Address of Facility Grove-Bowersox Funeral Home, 21. Signatule of Funeral Service Licensee ames Q. Baulersa 50 South Broad Street Waynesboro, PA 17268 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retw Immediate Cause (Final Onset and Death Atheroscherotic Coronary Physician/ Vascul disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician debetached for use as the burial Physician/Medical Atrial fibrill ation IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 18 months?

1 Yes 2 No
9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Aspiration 1 Yes 2 No 3 Probably Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy performe 2 No Yes **Division of Vital** the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of Injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 \square Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director, A' 1 Yes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check anivione)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Aparna Johnal

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

5601

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Grafflying Number Practioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0062735

29c. License number

d at the time data and place, and due to the cause(s) and manner as state

Loch Raven Blvd, Baltmore, MD 21280

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Jise" Medical Jahnson 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meggar 419 LowerGeomesCreat Room 20000Age (In vrs. last birthday) ate of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Min (Month, Day, Year) Country) Director Renosu VODIC october 20 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 54191 reek 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 🐪 No 1 Never Married 2 Married Completed by 1 Yes Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Divorced Specify: Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ lifford Summers Melon Pauline Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 ge 1 and 2 sh it of Health a If item 27 is uctis Johnson-Kushn 1191 aus-Garrac Cipeu front Moru bod 21839 Baltimore, 200200010A 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 20c. Location - Gity or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) LOTOMAN 1 GEORGI 20 Cumberland, Maryland 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Exchham-Maderzie Funezi Have, P.A. 8 East Main Street, Longroning 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ cule disease or condition resulting in death) homones Medical Due to (or as a consequence of): Examiner 5 cles alma Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for sela nonecollance of that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 I FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day Year ed by the a 1 ☐ Yes 2 € 9 ☐ Unknown 9 Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed ipage 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by mulleten Records, To the Hospital or Attending Physician; The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 Yes 2 No Yes No director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 2 210 Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 \square Pending Accident Investigation 6 Could not be Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2124

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

scood was

32. Registrar's Signal

bo MD

SEP 20

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 30993 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 09 Month 04 2010 ar JOANNE F. KULLMAN 6:15 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TALBOT HOSPICE HOUSE **EASTON** TALBOT | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 01/11/1937 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 73 177-28-9275 PA Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No TALBOT MD EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8134 NORTH FORK BOULEVARD 21601 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH A. LOUGHRAN ANNE HUGHES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH C. KULLMAN/HUSBAND 8134 NORTH FORK BLVD., EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN MEMORIAL PARK 09/10/2010 EASTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 200 S. HARRISON ST., EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tustatio Months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 🖾 No 1 ☐ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

23a or 28a-f show

Directo

Funeral

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Completed

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r than "natural", or items 23a or 28a-f shorthe Medical Evan in the metilled at

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death v

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Int. If Item 27 is marked other than "natural", or ite

7 is marked other traumatic event, I

Department of Health Important: If Item 27 any injury or other troope.

Baltimore, Maryland 21215-0036

Examiner attending physician and for use as the burial-transit signed by the a s been signated b page 2

The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Physician/Medical ۾ Completed Be Certification: To funeral filled in by the

25. Was case referred to medical examiner? 1 Yes 2 No

1 Natural 5 Pending investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 4 Homicide

29a. Certifier (Check only one)

29b. Signature and title of certified

30. Name and address of vers

28a. Date of Injury (Month, Day, Year)

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Mary

28f. Location (Street and Number or Rural Route Number, City or Town, State)

To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

RS 12

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

State Registrar

Medical

31. Date filed (Month SE)

Aueme

pleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30994 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Louis L. Kibler, Sr. Medical September 2010 11:00A^M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1060 Stonington Drive Arnold Anne Arundel Social Security Number Date of Birs. (Month, Day, Yea If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 1 🛛 M 2 🗆 F 82 Months Days Hours 220-22-7321 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director MD Anne Arundel Arnold 1 Yes 2 X No 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 1060 Stonington Drive 21012 USA items death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Korean o. Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Tes 2 No Specify: "natural", White 3 Widowed 4 Divorced Completed Specify: Year or Dates 27 is marked other than "natural traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Executive Machinery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward L. Kibler Lily May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other traum Kathryn Kibler / Wife 1060 Stonington Drive Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Strial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place
Lakemont Memorial
Gardens Davidsonville, MD 21. Signature of Full Service Licensee Barranco & Sons, P.A. 495 Ritchie Hwy, Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ arkinsons disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence oi). To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) __ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 9 Unknown been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Stenosis 1 🗌 Yes 2 🔽 No 3 🗌 Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed? Yes 2 No After this certificate 25. Was case referred to medical eral Director: After this certific filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes <u>۾</u> 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

Joseph

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

116

M.D

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		for State			State of	of Mary	yland			nt of F te of D		and N	∕lental H		21	110	3.0	995
		1. Decedent's Name	e (First, Middle	, Last)		_		Cer	unca	le oi L	Jeann		2. Date of I	<u>~</u>	. No. 👇 🔾	, 10	3. Time o	000
Physicia Medic		AGNES		VIRO	GINIA	CAS	SSAN	DRA	KAUI	'FMAN			SEPPT: 13, Day 2010 Year 11:00A					
Examin	er	4a. Facility Name (if			nber)	r)			4b. City, Town, or Location of Death Ladiesburg						c. County of Death Frederick			
Funeral		12465 Woodsboro Pike 5. Social Security Number 6. Sex 7. /					yrs. lasi	t birthday)		er 1 Year	If Under	24 Hrs.	8. Date of E	Birth	-	9. Birth	place (State	or Foreign
Director		220-16-0005					96 Yrs.			Days	Hours	Min.	March	°, °i	3914	14 Maryland		
and show	ior	Usual Residence of Decedent 10a. State 10b. County					10c. City, Town or Location										10d. Inside C	ity Limits
28a-f	Director	Maryland		La	diesb									1 🗌 Ye	s 2X No			
vith the 23a or st be r		10e. Street and Num 12465 Wo		o Pi	ke				10f. Z	ip Code 2175	57				. Citizen of nited		ntry? .tes	
items items	Funeral	11. Marital Status			2. Was Dece	edent Ever	in U.S.	13. V	Vas Dec			igin? (Sp	ecify Yes or N Rican, etc.)		14. Rac	ce - Americ	can Indian,	
after d I", or i xamin	þ		1 Never Married 2 Married 1 Yes 2 1 Yes, Give 2 Midowed 4 Divorced							ecity Cubai			Hican, etc.)		Bla Specify	ck, White,	_{etc.} nite	
hours natura lical E	Completed		15. Decedent's Education (Specify only highest grade completed)							ual Occupa			_	16	b. Kind of E		dustry	-
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d be fil	မှ	Dory Martin										ggie		Sta				
shoul raums		19a. Informant's Name/Relationship (Type, Print) Merhl Kaufman / grandson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 6616 Granville Ct./ Frederick, Marylan																
and 2 Health tem 2 other t		Merni Ka 20a. Method of Disp		/ gr	andso		20b. Plac	6616 ce of Dispos			e Ct		rederi Date		Maryla c. Location			
Page 1 nent of int: If i		1 Donation	Cremation 5 Other (S	3 ☐ Repecify)	emoval from	State	cen	netery, crem le Cem	atory or	other place			7,2010	1				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inpopartment of Health and Mental Hygiene. Inpopartment of the Z1s marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fun			1			22.	. Name a	and Addres	s of Facilit	ty St	auffer	Fu	neral			
70 E 8 9	_	23a. Party. Enter th	ond a	se.	era	00	dooth						1kersv		e, MD	217		
hysician/		shock, or hear Immediate Cause (F	t failure. List c Final	nly one	cause on ea	ich line.						cardiac	or respiratory	arrest,			Approxima Interval Bet Onset and	ween
Medical		disease or condition resulting in death)	n	e a.	Due to	Cor as a co	nsequer	ur nce of):	1604	Lure	219		1			+	minute	15.
Examiner	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):																
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eath. or: Aft.	Certificate:	1 Natural 2 Accident 3 Suicide	5 ☐ Pendin Investig 6 ☐ Could I	ation	(IVION	th, Day, Ye	ar)	injury	М	work?	Yes 2 🗌	No			_			
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within 24 hours and attending rupsycan. The law requires that the beart bettings be executed. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical	29a. Certifier 1	Certifying	Physici	a n: To the b	est of my l	knowled	ge, death o	ccured a	t the time,	date and	place, an	d due to the	ause(s	s) and mann	er as state	d.	
hin 24 the Fu nplete		only one) 3	☐ Medical E ☐ Certifying	Nurse F	on the bas ractioner:	sis of exami To the best	ination ar of my kr	nd/or investi nowledge, d	eath occ	urred at the	time, date	curred at and plac	t the time, date e, and due to	the cau	ise(s) and m	anner as st	ated.	inner stated.
S of Wit		29b. Signature and ti	itle of certifier	03	Your	5. N	n		29	c. License		14			Date signe			
		30. Name and addre	ss of person v	vho co	pleted caus	e of death	(Item 23	3a) (Type, Pr	int)									
6		Gerurt A	0.16	rippo	Jr.	M. D.	63	Thoma	s Tu	hnsin	Dr.	E	Freder	1616	, my	21	702	
State Registra	-	31. Date filed (Month	SFP:	172	32. R	egistyar's S	Signature استار ست	e A.	bo	Med								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 000 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Day Year Donald Anthony Kreseski M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 / 1 3 / 1 9 4 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 🙀 M 2 🗆 F Months Hours Min. 217-38-8244 **Director** Vrs 69 MD Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tiern 27 is amarked other than "natural", or items 23a or 28a-f show Important: If tiern 27 is amarked other than "natural", or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Manchester 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3308 Meadow View Drive 21102 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. ρ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Completed white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) computer systems Social Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Milton Kreseski Genevieve Andrzejewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21102 Marylyn Kreseski, wife 3308 Meadow View Drive, Manchester, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/15/10 st. Bartholomew C Manchester, Md 21. Signature of Funeral Service License 22. Name and Address of Facility Eline Funeral Home M00741 Hampstead Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ≏hysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Last Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Li retail documents.
Pregnant at time of death in the past 12 months? Month ed by the detached 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL FAILURE 2 No Completed 1 Tes 3 Probably 4 Unknown page 2 should CIRRHOSIS 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death?

1 Yes 2 No autopsy this certificate Yes 2 completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 1 유 1/2 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Magner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of after death. Director: After t 28d. Describe how injury occurred 1 Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. ☐ Homicide determined City or Town, State) 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 To the within 2 only one) 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) WJL

DHMH 17 Rev 7/2009

Registrar

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

31. Date filed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Mary Lou Knous		State of Maryland / 1-For State Registrar	Certificate of		id Mental H	, ,	g. No. つ	2000	
Physicia Medical Exami		Decedent's Name (First, Middle,Last) MARY LOU KNOTTS				2. Date of Death Month September	Day Year	3. Time of Death 2215 hrs	
		4a. Facility Name (if not institution, give street and number) In front of 14702 Mercersburg Rd		4b. City, Town, o	or Location of Death		4c. County of Death Washington		
Funeral Director		236-54-8683 _{1 M 2 K} F 7	(In yrs. last birthday) 2 Yrs	If Under 1 Ye Months Da			h(MM/DD/YYYY) 9. Bi Forei		
nd show any	٦٢	Usual Residence of Decedent 10a. State MD WASHINGTON			10d. Inside City Limits 1 Yes 2 No				
h the Maryla 3a or 28a-f	l Director	10e. Street and Number 14702 MERCERSBURG ROAD		10f. Zip Code 21722		10	g. Citizen of What Cou	Intry?	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	3 X Widowed 4 Divorced If Yes, Give Year or Dates:	X No 1	es, specify Cuba	ispanic Origin? (Sin, Mexican, Puerto specify:	Rican, etc.)	White, etc. Specify: WHITE		
1036 vithin 72 hour ene. er than "natu Medical Exan	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5-10)	ation (Give kind of e. DO NOT use reti		STATE OF MENTAL F	MD			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle, Last) BOYD ELLIS, SR.				EE BROW	N		
MD 21 td 2 should tlth and Me m 27 is ma sumatic er	٩	19a. Informant's Name/Relationship (Type, Print) CYNTHIA HONARD (DAUGHTER)				per, City or Town, State MISH, WA 9	e, Zip Code) 8290		
Baltimore, permit. Pages I an Department of Hea Important: If iter		20a. Method of Disposition 1 Burial 2 Coremation 3 Removal from Stat 4 Donation 5 Other Specify:	SMI IH2BOKG	CREMATORY	Y SEPT 201	. 26, 0	20c. Location - City or Town, State SMITHSBURG, MD		
11		21. Signature of Funeral Service Liverisee Kobert C. Fislols	-		W. KING ST	., MARTINS	SBURG, WV 254	0x 821, 02	
Physician /Medical Examiner	1	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Injuries		ne mode of dying	, such as cardiac o	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death	
	<u>_</u>	or condition resulting in death) Due to (or as a consequence of the conditions, if any, leading to immediate or conditions, if any, leading to immediate or conditions, if any, leading to immediate or conditions, if any, leading to immediate or conditions, if any, leading to immediate or conditions or condition resulting in death).							
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Vital Records, P.O. Box 68760, system: The law requires that the death certificate be executed his certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - transit	hysician/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Ectopic pregna		1 00	Day Year			
s, P.O. nires that the signed by d he detach	ā	Part II. Other significant conditions contributing to death b	out not resulting in the ur	nderlying cause (given in Part I.		acco use contribute to		
Division of Vital Records, P.O tal or Attending Physician: The law requires that I is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Completed	25. Was case referred to medical		26 Place	of Death (Check o	24a. Was ar autopsy perform 1 Yes 2	prior to death?	topsy findings available completion of cause of	
Vital	ě	examiner? 1 Yes 2 No Hospital: 1 Inpatient		3 DOA	Other		esidence 6 🗸 Other	: Scene	
ion of tending P cath. for: After the funen	I	27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation 28a. Date of Injury (Month, Day Yea Sep 20, 2010	28b. Time of In 2205 hrs		ry at Work? Yes 2 ✔ No		w injury occurred ver by minivan		
Divisation At urs after durs after durs after dilled in by	Certification	3 Suicide 6 Could not be determined (Specify) Loca	reet and Number or Ru te) 2 Mercersbrug Rd, (
	평	29a. Certifier 1 Certifying Physician: To the best of my k one) 2	nowledge, death occurrentation and/or investigation	ed at the time, da	ate and place, and , death occurred a	due to the cause(t the time, date an	s) and manner as state and place, and due to the	ed. e cause(s)	
F 3 F 8	Me	29b. Signature and title of certifier		29c. Licens		1	29d. Date signed (Mor		
	-	30. Name and address of person who completed cause of dea	,				September 22, 2	010	
Sta	ite	Russell Alexander MD. Assistant Medical		Penn Street,	Baltimore, MI	21201			
Registi		31 Date fled (Months Car, Year) 32. Registrar's	garre		· · · · · · · · · · · · ·				

10-06686 Christine List Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Christine List		State of Maryland / Departme 1- For State Registrar Certifica			Menta		201	0 30998				
Physic		Decedent's Name (First, Middle,Last)				2. Date of De		3. Time of Death				
Medical Exam	ine						er 5, 2010	0232 hrs				
		Facility Name (if not institution, give street and number) Yellow Springs Road		City, Town, or Lo	ocation of D	eath	4c. County of De Frederick	ath				
Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birth		If Under 1 Year	If Under 2	4Hrs 8 Date of B	irth(MM/DD/YYYY) 9. I	Rithriago (State or				
Director		214-76-3357 1 _M ×× _F 46	Yrs,	Months Days		Min. Januar	ry 27 1964	eign country Maryland				
		Usual Residence of Decedent	113,			Julia	-, -, -,	boundy Flat y				
w any		10a. State 10b. County 10c. City, Town of						10d. Inside City Limits				
yland -f sho	후	Maryland Frederick Frede						1 Yes 2 X No				
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Heath and Marulal Hygiene. Int: If item 27 is marked other than "matural", or items 23a or 28a-f show any rother traumatic event, the Medical Examiner must be notified at once.	Director	6085 Fountain Drive]1	10f. Zip Code 2170	12		10g. Citizen of What Co USA	ountry?				
with these 23a	la I	11. Marital Status 12. Was Decedent Ever in U.S.	13 Was F			(Specify Yes or No						
death or item	Funeral	1 Never Married 2 Married Armed Forces?	If Yes,	, specify Cuban, M	texican, Pu	erto Rican, etc.)		Race - American Indian, Black, White, etc.				
after ral", o	by F	J VVIdowed 4 Divorced in res, Give Year	1 Y	es XX No s	specify:		Specify: Te	white				
hours "natu	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		Usual Occupation of working life. D			16b. Kind of Busines	s/Industry				
)36 thin 72 te. than	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Ba	ank T	eller			Bankir	19				
5-0036 led within 7' Agiene. other than the Medical				18.	Mother's Na	ame (First, Middle,		-8				
21215-0036 unld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be					ed Gries	_					
e, MD 21215-003 1 and 2 should be filed withi Health and Mental Hygiene item 27 is marked other tr traumatic event, the Med	ဥ						mber, City or Town, Sta					
e, MC l and 2 sl Health ar item 27		20a. Method of Disposition 20b. Place of (Disposition	n (Name of cemet		Date	20c. Location - City of					
Baltimore, permit. Pages 1 and Department of Heal Important: If iten		1 Burial 2 Cremation 3 Removal from State crematory	y or other	place) ematory		9-13-2010	•	k, Maryland				
altir mit. F partme porta ury or		4 Donation 5 Other Specify: Stauffe 21. Signature of Funeral Service Licensee					Funeral Hom					
		Sharow Camelle Eline	162	1 Opossu	mtown	Pike, Fr	rederick, M	Maryland 21702				
Physician /Medical	6	23a. Part I. Enter the disease, or complications that caused the death. Do not e failure. List only one cause on each line.	enter the n	mode of dying, suc	ch as cardia	c or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and				
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):						Death				
		Sequentially list conditions, b										
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause										
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50, te be executed ysician and burial - transit	edical Examiner	d										
0, be ex	edic	UNPENDED AMENDED										
(68760, certificate be e ending physicia use as the buria		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth	- Cotol é	death 3	Estania - re-		23d. Date of deliver					
Box 6876 death certificate he attending phy d for use as the b	sician/M	past 12 months? 4 Pregnant at time of death	Fetal d	(Specify)	Ectopic preg	mancy	Month	Day Year				
BO) he deatly the att	Phys	1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in										
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	ð	Part II. Other significant conditions contributing to death but not resulting in	1 the unde	erlying cause giver	n in Part I,		bacco use contribute to					
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Division of Vital Records, tal or Attending Physician: The Law requir rs after death. sl Director: After this certificate has been sited in by the funeral director, page 2 should the complete that the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the	To Be	examiner?	atient 3	DOA Othe	00.0		Residence 6 🗸 Othe	r Scene				
ing Ph		27. Manner of Death 28a. Date of Injury 28b. Tim	ne of Injury	/ 28c, Injury at		28d. Describe h	ow injury occurred					
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lospit. 4 hour funers		200 Codifica		-4 U . V			Road, Frederick, M					
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ledical	one) 2 Medical Examiner: On the basis of examination and/or investigation	occurred a stigation, i	at the time, date a in my opinion, dea	nd place, a ath occurred	nd due to the cause d at the time, date a	e(s) and manner as stat and place, and due to th	ted ne cause(s)				
F 3 F 3	₹	and manner stated. 29b. Signature and title of certifier		29c. License nu			29d. Date signed (Mo					
		almin 1		O.C.M.E			September 5, 20					
,	f	30. Name and address of person who completed cause of death (Item 23a)										
_ (e			Penn St	treet, Baltimo	re, MD 2	1201						
Sta Regist	:Le	31. Date filed (Month Pay Year) 7 2010 32. Registrar's Signature	hours	ef al								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0335 6 2 10 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and Town, or Location of Death **Examiner** GUVIE Uc HEN 7. Age (In yrs. last birthday) er 1 Year If Under 24 Hrs. . Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. 574934 Director West Virginia 30 - 1722Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 Yes 2X No McHenry Garrett MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral items 23a U.S.A. 21541 Pysell RD 255 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black White etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural", 3 ₩ Widowed 4 □ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Trucking Co. permit. Page 1 and 2 should be filed wit. Department of Health and Mental Hygier Important: If item 27 is marked other tany injury or other traumatic event, the once. Truck Driver 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Lucas Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) McHenry, MD 21541 255 Pysell RD., Rodney D. Lucas/ Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory enter place)
Countryside
Crematory 1 🗌 Burial 2 🛣 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 9/25/10 Davidsville, PA Signature of Fundral Service Ligensee 22. Name and Address of Facility Newman Funeral Homes P.A. Mall Grantsville,MD 21536 St., 179 Miller 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months? Month Day Year Pregnant at time of death 2 No s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 🗎 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Yes 2 🗀 No ျှ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 esidence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural within 24 hours after death. To the Funeral Director: After injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

Registrar DHMH 17 Rev 7/2009

State

Medical

29a, Certifier (Check

Yan

only one 29b. Signature

leted cause of death (Item 23a) (Type, Print)

Registrar's Signatur

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1 📃 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September ^D 1 2, 2010 Erma Marie Lachnit 3:22 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7 East Aztec Street Aberdeen Harford Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 - M 2 X F Months Hours (Month, Day, 19<u>45</u> 216-48-0789 65 Director Maryland Usual Residence of Decedent items 23a or 28a-f shov ner must be notifled at 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at 10a, State 10d. Inside City Limits Director Carroll Westminster 1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21157 30 Locust Street, apt 305 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: white 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Gustav Lachnit, Jr. Mildred Stacknick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 East Aztec Street, Aberdeen, MD 21001 Teresa A. Donovan, niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once, 1 Display Burial 2 Cremation 3 Removal from State Moreland Memorial Pk 9/16/2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 26a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death hock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Urosepsi Medical Due to (or as a consequence of): un Odisease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ ascula 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? other Specifys Home Other: 4 Nursing Home 5 Residence 2 **U**No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier xamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of Certifying Nurse Practioner: To the only one) Signature and title of certified 29c. License number 29d. Date signed (Month. Dav. Year) WJL

State Registrar 30. Name and address of person who completed caus

death (Item 23a) (Type_Print)